

Mobile Health Teams, Decolonization, and the Eradication Era in  
Cameroon, 1945-1970

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## **Abstract**

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This dissertation examines the intersecting changes of African decolonization and the post-World War II internationalization of public health by showing how Cameroonian and French health officials shaped global health programs on the ground in the 1950s and 60s. I approach this topic through the lens of two tightly interwoven developments in Cameroon: the history of colonial mobile health teams created by French military doctors and the advent of postwar global disease eradication campaigns. While colonial medicine and international health are typically treated as distinct historical subjects, I argue that global disease eradication programs in this period in Cameroon relied entirely on colonial mobile health teams and their reformulation after independence as a basis of infrastructure, personnel and knowledge. I specifically assert that Cameroonian and French health officials positioned mobile health teams as cornerstones of national health policy and regional health coordination in Central Africa and, in turn, as the basis for operations of attempted global disease eradication programs within Cameroon. As Cameroonian, French and international health officials negotiated the work of the mobile health teams through decolonization and the first decade of the independence, they were moreover charting new structures of authority and control over medicine and public health between the global and the local, and forging an international politics of public health rooted in the particular tensions of decolonization in the country. My project thus demonstrates how Africans charted new models for public health through decolonization, models that reflected both the deeply enduring impact of empire and a new post-colonial politics.

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## **Dedication**

To my parents and to Dale, for being my home no matter where I went.

## Introduction

In 1965, Dr. Jean Claude Happi, the Commissioner General of Public Health for Cameroon, welcomed Central African, French and international health officials to the first meeting of a new regional health organization based in the capital city of Yaoundé. The *Organization for Coordination in the Fight against Endemic Diseases in Central Africa* (OCEAC) aimed to coordinate mobile health teams, which had originally been created by French military doctors under colonial rule, across its five member states.<sup>1</sup> The mobile health team model remained the pride and joy of French military doctors, and its enshrinement in independent African health administrations marked the enduring impact of empire on public health. Moreover, this new regional health organization formed three years after independence represented a new politics of health in independent Cameroon, rooted deeply in French colonial medicine but also charting a course for this system in the new nation. While a French military doctor with a long career of work in the mobile health service in the colonies held the organization's top technical leadership post, Cameroonian and other Francophone Central African health ministers also advanced this organization as a progressive form of regional African integration.

This meeting moreover served as the forum for negotiations for the launch in the member states of the first major global health program after independence. Representatives from the American Centers for Disease Control and from the World Health Organization came to the meeting of OCEAC to discuss plans for the launch of a global smallpox eradication program in Cameroon and member countries.<sup>2</sup> At the exact time that this new regional

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<sup>1</sup> French name: *Organisation de Coordination pour la lutte contre les Endémies en Afrique Centrale*. Member states included Cameroon, The Republic of Congo (Brazzaville), Gabon, Central African Republic, and Chad.

<sup>2</sup> *Rapport Final de la Première Conférence Technique de l'O.C.C.G.E.A.C.*, Yaoundé du 7 au 11 Décembre 1965.

organization took shape, planning for the smallpox program raised fundamental questions about how it would work within an evolving national and regional politics of public health, as well as in relation to the medical infrastructure and personnel developed through colonialism. Five years after independence in French Cameroon, this meeting captured a vital crossroads in an ongoing negotiation of how Cameroonian health officials would develop the country's own internal administration of public health, and how this in turn would be constituted by the relationship to France, other African countries, and international health organizations.

The politics and paradoxes of this meeting in Yaoundé, with its mix of African, French and international health officials, to plan for the first major global disease eradication program after independence ultimately captures many of the questions that this dissertation seeks to explore. This project poses an overarching question of how decolonization forged new relationships of colonial medicine, international health, and national and regional health administration in newly independent African nations. I approach this question through the lens of two tightly interwoven developments in Cameroon: the history of French colonial mobile health teams and the advent of postwar global disease eradication campaigns. The convergence between the mobile health teams and postwar global disease eradication campaigns ultimately explains how frameworks of colonial, national, regional and international health came together from 1945-1970 in rural public health intervention in Cameroon.

The period after World War II was a transformative time for public health due in part to the creation of the World Health Organization and the increasing optimism about the possibility of entirely eradicating specific diseases from the globe. International health efforts turned decisively to a focus on technological approaches to combatting disease and to the idea that these methods could be universally applied across different geographic and social contexts. The

dream of global disease eradication represented the height of this faith in universal technological solutions.<sup>3</sup> In the postwar “eradication era” international organizations, colonial and national governments poured immense resources into an ultimately failed attempt at eradicating malaria and a successful campaign to eradicate smallpox from the globe.<sup>4</sup> By the end of the 1960s in Cameroon, the eradication era had likewise produced both notable success on smallpox and stunning failure on malaria.

The story of postwar international health in Cameroon cannot be understood, however, without attention to French colonial medicine and its postcolonial manifestations. Postwar reforms to the French colonial medical infrastructure deeply shaped the implementation of international disease campaigns both during the colonial period and after independence. The period after WWII was also a transformative time for colonial rule in Africa, as European colonial governments implemented broad programs of economic and social reform. The centerpiece of the French vision for postwar colonial medicine was the expansion of a mobile health team service meant to be the basis for biomedical intervention in rural Africa. Originally created by French military doctor Eugène Jamot in the interwar period to combat sleeping sickness, the mobile health teams offered a new model for medical intervention to extend beyond the hospital or dispensary. Through this model, teams overseen by a French military doctor and composed of African medical auxiliaries traveled directly to rural areas to assemble people for examination, vaccination and in some cases treatment. After World War II, French colonial officials expanded the mandate of the mobile health service to address a variety of

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<sup>3</sup> Nancy Stepan, *Eradication: Ridding the World of Diseases Forever?* (Ithaca, NY: Cornell University Press, 2011).

<sup>4</sup> Randall M. Packard, *A History of Global Health: Interventions in the Lives of Other People* (Baltimore: Johns Hopkins University Press, 2016), 133. Packard refers to the ‘Era of Eradication.’ He points out that the two major eradication programs “dominated the international-health landscape” for much of the 40s, 50s and 60s, 134.

diseases, such as smallpox, malaria, and leprosy. The *Service Général d'Hygiène Mobile et de Prophylaxie* (SHMP) represented the central component of 'preventive' medicine and the most intensive form of biomedical intervention for the majority rural population in French colonial Africa. As a primary site of the development of the mobile health team model and of postwar investment for France, Cameroon represented a central focus of French ambition for the mobile health team model as a modernizing reform.<sup>5</sup> The teams left a history of coercive practice and instances of medical disaster in their wake in Cameroon, but they also became the pride and joy of French military doctors, and of many Cameroonian medical elites, due to their immense success in combatting sleeping sickness in the interwar period.<sup>6</sup>

The triumphalist narrative of the teams among both French and Cameroonian medical personnel endured the political changes wrought by decolonization. France maintained powerful economic and political influence in Cameroon after independence and the realm of medicine was no exception to this trend. After independence, Cameroonian health officials largely upheld the model of the mobile health teams, including the role of French military doctors in their operations. The mobile health teams became a central component of the early postcolonial health system in Cameroon.

The teams were also, I show, the vehicle for global disease eradication programs in Cameroon the 1950s and 60s. The malaria and smallpox eradication programs of the 1950s and 60s relied on the French colonial mobile health teams and their reformulation by French and

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<sup>5</sup> Guillaume Lachenal, *Le médicament qui devait sauver l'Afrique : Un scandale pharmaceutique aux colonies* (Paris : La Découverte, 2014), 78.

<sup>6</sup> The most infamous disaster of the teams happened in Jamot's time, when a subordinate administered an overdose of the drug tryparsamide and blinded an estimated 700-900 people in Bafia, Cameroon. Jean-Paul Bado, *Eugène Jamot, 1879-1937 : Le Médecin de la maladie du sommeil ou trypanosomiase* (Paris : Éditions Karthala, 2011). In 1954, the teams administered lomidine injections using contaminated water in Yokadouma, Cameroon. These injections produced bacterial infections, leading to 300 cases of gangrene and 32 deaths. Lachenal (2014), 147-164.

Cameroonian health officials after independence as a basis of infrastructure, personnel and knowledge. Both Cameroonian and French health officials leveraged these international health programs as sources of material resources for the mobile teams, while also imposing their own parameters on how disease eradication programs could operate logistically and politically within Cameroon. Postwar international health programs and the French colonial mobile health teams each have a rich history on their own terms, but in this work I reframe their significance in Cameroon by considering how they came together and what this meant for public health and medical administration in the independent state.

I ultimately argue that the mobile health teams became the central site of negotiation for Cameroonian, French and international health officials over the relationship between colonial medicine, national health administration, and international health programs in rural health intervention through decolonization and the first decade of independence. The work of the mobile health teams raised fundamental questions about public health in the Cameroonian state in the intertwining eras of decolonization and disease eradication. In the context of a majority rural population, low numbers of biomedical personnel, and a sparse spread of medical facilities, the mobile health teams became central to visions of how the French colonial government sought to extend medical interventions and in turn how international health agencies and programs could do the same. Over time, this overlapping work of models of international and colonial health would spawn new questions about what exactly rural health intervention should entail in the independent Cameroonian state.

As the mobile teams performed the work of disease eradication programs and thus became implicated in both their success and failures, they became a central lens on how the ideals of international health worked through local contexts. This work raised questions of

what constituted the scientific, cultural, and locally-rooted logistical expertise needed to execute such campaigns, and how this expertise worked between the scale of the Cameroonian village and a globalized vision of public health work. These questions included the necessary conditions for medical teams to access people and places for public health intervention, with the stakes of this access immeasurably heightened through the absolutist goals of disease eradication. Global disease eradication programs in the postwar period, despite their one-size fits all ambitions, necessarily relied on ‘local’ medical operations, personnel and expertise.

Decolonization, however, brought into question who and what would represent the ‘local’ authority over health in engagement with international health institutions. While this question certainly arose for other former French colonies in Africa (and other colonial territories), Cameroon offers a particularly rich case study of decolonization and international health due to how its political status-at the intersection of colonial and international administration, and of French and British imperialism-intersected with questions of authority over public health. As a United Nations Trusteeship under joint French and British administration in the 1950s, the site of an anti-colonial movement that grew into military conflict, and then a bilingual Federal Republic joining together former French and British territories in the 1960s, Cameroon was a place where the political stakes of the ‘local’ hold on public health through decolonization were particularly charged.

The new postwar period of public health in Cameroon developed in the political context created by the formation of the United Nations and Cameroon’s designation as a UN Trusteeship under joint British and French administration.<sup>7</sup> With the Trusteeship status

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<sup>7</sup> Cameroon was first a German protectorate from 1884 to 1916. The territory was divided after WWI and made into League of Nations Mandates under British and French administration. With the end of the League of Nations and of WWII, the Cameroons became ‘Trust territories’ of the United Nations, still under British and French administration.

institutionalizing international oversight of colonial administration, this arrangement heightened the political stakes of public health programs in the territory. Through required reports to the United Nations and during visits of a UN Trusteeship delegation to the territory, France sought to showcase the progressive nature of its administration. One of the ways in which it did this was by showcasing modernizing postwar reform in Cameroon, particularly the work of the mobile health teams.<sup>8</sup> In the 1950s, when the newly created UN agencies of the World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF) began to fund a malaria eradication pilot program in French Cameroon run by the mobile health teams, the territory became a central site of research for malaria eradication in Africa. Through this program, French military doctors and colonial officials carved out a space as local intermediaries of postwar international health in Cameroon, all while upholding this work as representative of the ideals of Trusteeship.

While French military doctors assumed the mantle of local experts in the 1950s, after independence this position became more complicated. Who controlled the medical administration in independent Cameroon and on what model would it be based?<sup>9</sup> Through decolonization, the mobile health teams ultimately became central to how both Cameroonian and French health officials forged the place of colonial models of medicine, and of French doctors, in the independent state. Multiple influences ultimately shaped this reorganization of the mobile health teams within Cameroon: the professional ties between French and

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<sup>8</sup> Lachenal (2014), 78.

<sup>9</sup> In 1961, the entire state medical corps in former French Cameroon included 54 French military doctors, 28 Cameroonian doctors, and an additional 1313 Cameroonians working as nurses and medical auxiliaries. Table 1 provides additional detail.



Cameroonian medical personnel, the emerging affiliations between independent African states, and the internal fault lines of British and French colonialism within independent Cameroon.

International health agendas in the eradication era also deeply shaped the status and the work of the mobile health teams after independence. These agendas worked in two distinct and sometimes opposing directions on the teams. On one hand, as international health institutions continued to prioritize campaign-style public health programs through the launch of a global smallpox eradication program, Cameroonian and French officials asserted the mobile health teams as central to engagement with international health resources, programs and personnel. How Cameroonian health officials positioned the mobile teams after independence was thus also a question of how to forge an international politics of health coordination. At the same time, the World Health Organization began in the 1960s to propose reforms to rural health systems, and the embrace of these reforms by Cameroonian health officials created a conflict with French military doctors who jealously guarded the necessity of the mobile health team model. In forging a new politics of international health after independence, Cameroonian health officials thus contended with both the influences of international health and the ongoing imprint of colonial medicine. Some of the most important debates about rural health intervention in postcolonial Cameroon happened through the negotiation of how these two factors would come together.

The negotiation by Cameroonian and French health officials of international health through decolonization reflects Jean-François Bayart's concept of "strategies of extraversion" and Frederick Cooper's characterization of the "gatekeeper state" established by the colonial state and adopted by postcolonial African states in which the ability to leverage external resources became a central, if not primary, source of state power. Cooper characterizes colonial

states as having “weak instruments for entering into the social and cultural realm over which they presided, but they stood astride the intersection of the colonial territory and the outside world.”<sup>10</sup> Thus while French military doctors saw the mobile health teams as a powerful tool for entering in the ‘social realm’ of Africans, this impact remained uneven in many ways. I assert, however, that in the 1950s the authority over the mobile health teams became the primary point of interaction with ‘the outside world’ in the realm of international health due to the focus on disease eradication at the time. This convergence between colonial medicine and international health established a certain dynamic of state administration with which Cameroonian health officials would contend. Through the 1960s, the position of mobile health teams in the national administration thus became a central area of governance through which Cameroonians navigated international health initiatives in the state after independence.

Part of this forging of an international politics of health happened through an internal process of creating a harmonized national medical administration. In 1961, the question of the place of the mobile health team model in independent Cameroon became emblematic of a broader question about forming a national medical administration across the fault lines of French and British colonial medical infrastructure. After French Cameroon gained independence in 1960, it joined with part of the former British Cameroons in 1961 to form an officially bilingual Federal Republic.<sup>11</sup> After 1961, Cameroonian officials thus faced the unique

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<sup>10</sup> Frederick Cooper, *African since 1940: The Past of the Present* (Cambridge: Cambridge University Press, 2002), 5. Jean-François Bayart, *The State in Africa: the Politics of the Belly* (New York, NY: Longman, 1993).

<sup>11</sup> The entirety of the British Cameroons United Nations Trusteeship included a Northern and a Southern Territory on the western border of French Cameroon, and the British essentially administered the territories as part of Nigeria. The French-administered territory of Cameroon became independent on January 1, 1960. In a February 1961 UN-run plebiscite, people living in each of the British Cameroons voted separately on whether to become independent by joining with either Nigeria or the newly independent *République du Cameroun* to the east. The British Northern Cameroons voted to become part of Nigeria and the Southern Cameroons voted to join with the *République du Cameroun*. Delegates from the two territories of the new Cameroon met at the Fomuban conference of July 1961 to create a constitution and framework for the state. The resulting system for the Federal Republic of

regional circumstances of building a national health administration from former British and French territories. Throughout the 1960s, Cameroonian medical elite and citizens debated the future of the mobile health teams across the former British and French territories and the role of French doctors in the newly constituted bilingual state. Francophone Cameroonian health officials asserted the importance of the teams for the state and sought to solidify the model as a standardized national system. Through this process, harmonizing the mobile health team model became part of Cameroon's formation of an external politics on matters of health.

These questions of external relations further developed at a regional level between Cameroon and neighboring African states through the formation of the regional health organization, OCEAC, in Yaoundé. In creating the organization, francophone Cameroonian and French health officials asserted the mobile health team model as a unifying inter-state framework for health coordination after independence. In so doing, they both forged an international politics of health at a regional scale unto its own and created a new intermediary for the work of international health programs in this region. French military doctors led OCEAC and thus also guarded a central role in the controlling the resources of international health in Cameroon.

When the global smallpox eradication program began in the late 1960s, Cameroonian and French health officials used the existence of the mobile health teams and the framework of OCEAC to shape the functioning of this campaign in specific ways. I assert that these three developments of the mobile health teams through national standardization, regional

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Cameroon created two states: West Cameroon, the former British Southern Cameroons, and East Cameroon, the former French territory. The Federal Republic of Cameroon came into being on October 1, 1961 and comprised the territorial boundaries of Cameroon that are still in existence today. The federal system was ultimately abolished in 1972 and a unitary national government created.

coordination and ongoing connection to the French thus in turn deeply shaped the operation of post-independence health international programs in Cameroon in the 1960s.

The failures of malaria eradication efforts in Cameroon and across the world, however, also catalyzed new forms of direct collaboration between the World Health Organization and Cameroonian health officials that marked a departure from a strict adherence to the colonial mobile health team model. In the wake of this failure, the WHO advised, and Cameroonian health officials began to adopt, modifications to the colonial model of mobile health teams in a way that provoked contention with French doctors involved with the state. By the late 1960s, Cameroonian officials faced a crossroads on how to navigate the dual and interwoven trajectories of colonial medicine and international health. While the changes of decolonization had pushed Cameroonian and French health officials to reposition the mobile health teams in a new political era, the failures of the eradication era led to a decisive step away from this model.

By examining this history of colonial mobile health teams, decolonization, and international health, my dissertation thus shows how Cameroonians charted new models for public health in the state, models that reflected both the deeply enduring impact of empire and a new post-colonial politics. My focus is therefore not just on how the mobile teams implemented global eradication programs in a local context, although that constitutes a key part of this story. I am also interested in how the relationship between the mobile teams and global disease eradication programs shaped the conception of the interplay of colonial, national and international public health during a time of rapid political change. Highlighting this relationship shows that controlling international health directives and resources became an important realm of negotiation of decolonization in Cameroon. At the same time, the operation of ‘international health’ in Cameroon was not constituted solely by the relationship of the postcolonial state to

international health organizations. International health in its local manifestation was also formed through the navigation of colonial models of medicine and French doctors in the state, the meaning of the borders of European imperialism for medicine, and the forging of ties across African states. I thus demonstrate how the development of the mobile health team service along four key axes—within Cameroon, between Central African states, between Cameroon and France, and with international institutions—became central to the intertwined historical processes of the end of empire and the growth of global health programs.

### **Histories of Decolonization, Colonial Medicine and International Health**

My dissertation makes its contributions at the intersection of histories of decolonization, colonial medicine and international or global health. First, this work shows that the convergence of colonial medicine and international health were central to the functioning of public health through decolonization and early independence in Africa. Second, this project shows that public health was a key arena of governance through which African doctors and political officials negotiated new post-independence relationships among African countries, with European powers, and with international institutions. In this regard, it centers health and medicine as an important dimension of histories of internationalism and decolonization in Africa.

Before expanding on how these contributions relate to existing literature, I would like to draw attention to the implications of using the terms ‘international’ or ‘global’ health and explain how I have chosen to situate my project in relation to these terms. The term “international health” gained traction in the late 19<sup>th</sup> and early 20<sup>th</sup> century in reference to “a

focus on the control of epidemics across the boundaries between nations.”<sup>12</sup> Within the framework of “international health”, the term “global” was used in specific ways by the mid-20<sup>th</sup> century, notably beginning in the 1950s with the “Global Malaria Eradication Program.”<sup>13</sup> Some scholars have noted the different implication of “global health” as implying “consideration of the health needs of the people of the whole planet above the concerns of particular nations.”<sup>14</sup> Historians of public health have argued, moreover, that the World Health Organization drove the turn to the use of the term “global health” in the 1990s as it tried to position itself as a leader in a changing international context.<sup>15</sup> The term “global health” today thus conjures specific arrangements of funding and influence often driven by nongovernmental organizations, and much of it shaped by the response to HIV/AIDS.<sup>16</sup>

More recently, however, historians have begun to use “international” and “global” in reference to postwar public health in sometimes interchangeable ways.<sup>17</sup> In the edited volume *Global Health in Africa: Perspectives on Disease Control*, historians of Africa James Webb and

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<sup>12</sup> Theodore M. Brown, Marcos Cueto, and Elizabeth Fee, “The World Health Organization and the Transition from “International” to “Global” Public Health,” *American Journal of Public Health* 96 (2006): 62.

<sup>13</sup> Brown et al. (2006): 62.

<sup>14</sup> Brown et al. (2006): 62.

<sup>15</sup> Brown et al. (2006): 62. The authors argue that the WHO began to face a crisis in the 1980s due to budgetary and leadership problems. The World Bank meanwhile advanced its own agenda, pushing for massive reductions in public sector health services, and grew to be a leading force by the 1990s in international health. The authors argue that the WHO built off a new wave of literature in the 1990s about ‘global health threats’ in the form of infectious disease to reposition itself as an important leader in addressing these threats.

<sup>16</sup> Packard (2016), 273-304. Johanna Tayloe Crane, *Scrambling for Africa: AIDS, Expertise, and the Rise of American Global Health Science* (Ithaca, New York: Cornell University Press, 2013).

<sup>17</sup> Erez Manela, for example, has argued that the Smallpox Eradication Program was the first truly global health program, due to the level of coordination mounted beyond the national level. Erez Manela, “Smallpox Eradication and the Rise of Global Governance,” in *The Shock of the Global: The 1970s in Perspective*, ed. Ferguson et al. (Cambridge: Harvard University Press, 2010), 253.

Tamara Giles-Vernick “use the term ‘global health’ broadly to refer to the health initiatives launched within Africa by actors based outside the continent. In our usage, global health in Africa has its roots in the colonial period and came into its modern forms in the post-WWII era. This framework accommodates the continuities in external resource flows and the changing groups of actors, institutional configurations, and biomedical, financial and political priorities.”<sup>18</sup> While this framework presents a danger of anachronism of imposing the definition of global health, as used today, onto a time when this term was less common, it also productively emphasizes continuities, rather than ruptures, in external approaches to health in Africa since World War II.

Because this dissertation focuses in part on disease eradication programs that had explicit ambitions of a global scale, I refer frequently to “global health programs.” I deliberately foreground the stated global scale of disease eradication programs in order to contrast this vision with other geographies of public health envisioned by Cameroonian, Central African and French health officials—at the scale of the colonial territory, of the nation or of a health region consisting of francophone African states. Thus, the term “global health” in the period of this dissertation should be understood not in contemporary terms but in the terms of the concerns of the time, which framed the ambition of “borderlessness” in public health as primarily rooted in the goal of disease eradication.

The first main contribution of this dissertation is the illumination of the tightly interwoven developments of colonial medicine and international health on the ground in

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<sup>18</sup> James L.A. Webb, Jr. and Tamara Giles-Vernick, “Introduction” in *Global Health in Africa: Historical Perspectives on Disease Control*, ed. Tamara Giles-Vernick and James L.A. Webb, Jr. (Athens, Ohio: Ohio University Press, 2013), 3.

postwar Africa and the assertion that this relationship took on enduring and new forms in the first decade of independence. As Randall Packard has noted in his most recent work, *A History of Global Health: Interventions into the Lives of Other People*, histories of colonial medicine and international health have often been treated as distinct subjects.<sup>19</sup> He attributes this divide to an “academic division of labor” between those who study colonial medicine through the framework of a regional context and those who study international health through the lens of the history of medicine or of international organizations.<sup>20</sup> Specifically pertaining to Africa, a rich body of literature has explored connections between biomedicine and colonial administration. This scholarship has shown, among other things, how European colonial administrations often used medicine as a tool of control but also how Africans regularly adopted this medicine to their own ends, subverted its influence, and maintained their own forms of healing.<sup>21</sup> Works by Nancy Rose Hunt and Julie Livingston, for example, have focused on how Africans made meaning of illness, medicine and the body in changing social and political contexts, influenced both by biomedicine and “traditional” forms of medicine.<sup>22</sup> This dissertation, by contrast, does

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<sup>19</sup> Packard (2016), 14.

<sup>20</sup> Packard (2016), 347.

<sup>21</sup> The work on colonialism and medicine in Africa is extensive. Classic foundational texts in the field include: Steven Feierman, “Struggles for Control: The Social Roots of Health and Healing in Modern Africa,” *African Studies Review* 28 no.2/3 (1985): 73-147. Megan Vaughan, *Curing their Ills: Colonial Power and African Illness* (Cambridge: Polity Press, 1991). J. Comaroff “The Diseased Heart of Africa: Medicine, Colonialism and the Black Body,” in *Knowledge, Power and Practice*, ed. Shirley Lindenbaum and Margaret Lock (Berkeley: University of California Press, 1993), 305-329. Shula Marks, “What is Colonial about Colonial Medicine? And What has Happened to Imperialism and Health?” *Social History of Medicine* 10, no. 2 (August 1, 1997): 205-219. Maryinez Lyons, *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1900-1940* (Cambridge: Cambridge University Press, 1992). Frantz Fanon, “Medicine and Colonialism” in *A Dying Colonialism* (New York: Grove Press, 1967). Randall M. Packard, *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa* (Berkeley: University of California Press, 1989).

<sup>22</sup> Nancy Rose Hunt, *A Colonial Lexicon of Birth Ritual, Medicalization and Mobility in the Congo* (Durham, NC: Duke University Press, 1999). Julie Livingston, *Debility and the Moral Imagination* (Bloomington: Indiana University Press, 2005).



not focus on this broader scope of healing or individual experience of medicine, but rather examines the changing international context and institutional architecture of biomedicine through decolonization. I thus examine how the distinctly modernist pursuit of global disease eradication intersected with visions of state biomedicine during a time of rapid political change.

Alternatively, histories focused on international efforts against specific diseases or the work of international institutions tend to remain at a general level of engagement with specific African histories in order to achieve breadth.<sup>23</sup> As Packard has noted, historians have often noted the “interplay” of colonial medicine and international health, but “they have failed to recognize the extent to which these two phenomena form a single history.”<sup>24</sup> He offers the language of “entanglements” to describe the relationship between colonial medicine and international health.<sup>25</sup> Some recent works have begun to bring these two fields together in more

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<sup>23</sup> James L.A. Webb, Jr., *The Long Struggle against Malaria in Tropical Africa* (New York, NY: Cambridge University Press, 2014). Webb offers a focused case study in “The First Large-Scale Use of Synthetic Insecticide for Malaria Control in Tropical Africa: Lessons from Liberia, 1945-62,” in *Global Health in Africa: Historical Perspectives on Disease Control*, ed. Tamara Giles-Vernick and James L.A. Webb, Jr. (Athens, Ohio: Ohio University Press, 2013): 42-69. William H. Schneider, “The Long History of Smallpox Eradication: Lessons for Global Health,” in *Global Health in Africa: Historical Perspectives on Disease Control*, ed. Tamara Giles-Vernick and James L.A. Webb, Jr. (Athens, Ohio: Ohio University Press, 2013): 25-41. An important exception to this statement comes in Jennifer Tappan’s work on WHO and UNICEF-led efforts to address child malnutrition in Uganda. Jennifer Tappan, “The True Fiasco: The Treatment and Prevention of Severe Acute Malnutrition in Uganda, 1950-74,” in *Global Health in Africa: Historical Perspectives on Disease Control*, ed. Tamara Giles-Vernick and James L.A. Webb, Jr. (Athens, Ohio: Ohio University Press, 2013): 92-113.

<sup>24</sup> Randall M. Packard, (2016), 14, 347. Packard notes works by Helen Tilley, Deborah Neill, Sunil Amrith, and Nancy Stepan as exceptions that have begun to chart the relationships between colonial medicine and international health. Sunil Amrith, *Decolonizing International health: India and Southeast Asia, 1930-65* (New York: Palgrave Macmillan, 2006). Helen Tilley, *Africa as a Living Laboratory: Empire, Development and the Problem of Scientific Knowledge, 1870-1950* (Chicago: University of Chicago Press, 2011). Deborah Neill, *Networks in Tropical Medicine: Internationalism, Colonialism, and the Rise of a Medical Specialty* (Stanford, CA: Stanford University Press, 2012).

<sup>25</sup> Packard (2016), 13-14. The idea of “entanglements” has a broader resonance in Africanist scholarship, particularly in relation to colonial and postcolonial history. Achille Mbembe characterizes models of time in the African “postcolony” by entanglements, in contrast to linear models of time. He argues that the “postcolony encloses multiple *durées* made up of discontinuities, reversals, inertias, and swings that overlay one another, interpenetrate one another, and envelope one another.” In the field of healing, medicine and the body, Lynn Thomas has emphasized “historical entanglement” as a framework for tracing negotiations over reproductive

significant ways.<sup>26</sup> Works of Helen Tilley and Deborah Neill, for example, highlight connections between international scientific research and colonial medicine in the first half of the twentieth century. Packard's reframing of colonial medicine and international health invites new questions about how this relationship unfolded in different colonial spaces, evolved in the postwar period, and what the implications of this "entanglement" were for African health administrations after independence.

Recent scholarship has, for example, highlighted significant postwar tensions between European colonial powers and international health organizations in Africa. Jessica Pearson argues that, in regards to health, France shifted its "civilizing mission" to the discourse of development, as part of an effort to guard its empire while being in line with postwar international norms. She shows that French colonial health officials approached the UN health agencies with great skepticism, and they sought to reposition themselves as "international" experts in a new political landscape of public health.<sup>27</sup> My dissertation examines similar questions of claims to medical expertise between the colonial and international, but I focus primarily on how claims to this expertise and authority evolved, and multiplied, after

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concerns in Kenya between old and new, local and imperial. Julie Livingston in turn drew on this framework in her work on debility in Botswana to trace "entanglements" between the domains of "public health, Tswana medicine (bongaka), biomedicine and lay nursing care." Achille Mbembe, *On the Postcolony* (Berkeley: University of California Press, 1999), 14-17. Lynn M. Thomas, *Politics of the Womb: Women, Reproduction, and the State in Kenya* (Berkeley: University of California Press, 2003), 17-20. Julie Livingston (2005), 16.

<sup>26</sup> Packard (2016), 347.

<sup>27</sup> Jessica Pearson-Patel, "French Colonialism and the Battle against the WHO Regional Office for Africa," *Hygiea Internationals: An Interdisciplinary Journal for the History of Public Health*, 13. 1 (2016): 65-80, accessed January 25, 2017, doi: 10.3384/hygiea.1403-8668.1613165. Jessica Pearson-Patel, *From the Civilizing Mission to International Development: France, the United Nations, and the Politics of Family Health in Postwar Africa, 1940-1960* (Dissertation, New York University, 2013).

independence. Historians of Africa have not explored in-depth how the relationship of the colonial to the international in health shaped postcolonial health administrations.

There are multiple dimensions to that historical question, and it is also true that few works have dealt with what happened to colonial medical personnel and institutions after independence in Africa. Notably for this project, a key body of research on this topic focuses on Cameroon. Guillaume Lachenal's work advances key claims about the development of the scientific and medical fields in Cameroon through decolonization. His body of work shows how Cameroonian and French health officials used the celebration of colonial medicine, and specifically the celebration of mobile health team founder Eugène Jamot, to reframe decolonization in Cameroon as a peaceful transition, which would then support a post-colonial future of on-going close French-Cameroonian ties in the medical world.<sup>28</sup> On a second and related point, he shows how a sense of shared medical culture, professional order, and ties of "familiarity" between Cameroonian and French medical personnel shaped the world of scientific research after independence.<sup>29</sup> Lachenal's development of the idea of "familiarity" offers a framework for understanding why some Cameroonian medical elite maintained the close working relationships with French doctors that they did. My concern is not with intervening in this characterization of the French-Cameroonian medical relationship as such, but rather in reframing how it became constituted and in turn had implications in a wider

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<sup>28</sup> Guillaume Lachenal, "Célébrer le passé, construire le futur: l'indépendance et le microcosme médical au Cameroun," in *Les Indépendances en Afrique: l'événement et ses mémoires: 1957/1960-2010*, ed. Odile Goerg et al. (Rennes: Presses Universitaires de Rennes, 2013), 353-376.

<sup>29</sup> Guillaume Lachenal, "Franco-African Familiarities. A history of the Pasteur Institute of Cameroun, 1945-2000," in *Hospitals beyond the West: from Western Medicine to Global Medicine*, edited by Mark Harrison and Belinda White (Orient-Longman: New Dehli, 2009), 411-444. Lachenal draws on Bayart's uses of "familiarity" and "intimacy" to describe the ties between France and Africa: Jean-François Bayart, *L'état en Afrique: la politique du ventre* (Paris: Fayard, 1989). See also: Jean-Pierre Dozon, *Frères et sujets: la France et l'Afrique en perspective* (Paris: Flammarion, 2003).

international frame. Lachenal's work thus invites essential questions about how this reformulation of colonial medical ties operated within, and also shaped, the internationalization of medicine and public health in the postwar period.

I argue, therefore, that understanding the history of medicine and decolonization in Cameroon also requires attention to how French-Cameroonian medical ties became formulated through three related dynamics: through the relationship to international health organizations, to neighboring African states, and across the former British West Cameroon. I hold that the mobile health teams were central to a reorganization of the French-Cameroonian medical world in part because they were so central to the formation of an international politics of health for Cameroon.

Despite this growing attention to questions of medicine and decolonization in Africa, historians have given little attention to the convergence of colonial medicine and international health through the major postwar international health campaigns. Details of how these campaigns actually worked through colonial health systems in Africa and in independent states remain largely unexamined.<sup>30</sup> I assert that the precise relationship between international health programs and distinct arms of colonial medical administration, such as the military-influenced French mobile health teams, require more attention in order to illuminate exactly how such programs operated. Moreover, I aim to show how this operational relationship created new arrangements of international and colonial expertise on the ground in Cameroon, how it translated into the operation of public health campaigns, and how this arrangement unfolded after independence.

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<sup>30</sup> Webb and Giles-Vernick (2013), 5. They point out that the early postwar history of the WHO and other UN agency-funded health initiatives in African colonial territories or independent states 'are largely yet to be explored.'

The richest regionally-focused work on the functioning of international health campaigns in colonial and post-colonial states that deal with this period focus on areas other than Africa. Works by Sunil Amrith and Sanjoy Bhattacharya on India, for example, invite a rich basis for comparison.<sup>31</sup> As Amrith shows, Indian leaders in the 1950s adopted WHO campaigns as part of “narratives of progressive national development” and these campaigns became part of national policy.<sup>32</sup> Likewise, Amrith emphasizes that WHO officials “envisaged their task in opposition to the epidemiological and epistemological legacies of colonial medicine.”<sup>33</sup> This case presents an important question of periodization in comparative work on international health; WHO funding helped support a malaria eradication program in the 1950s in independent India, while a related malaria eradication pilot program in Cameroon operated through a colonial government. Moreover, the much less heavy-handed role of the British in medicine in India versus that of France in Cameroon after independence presents significantly different contexts. As I discuss, Cameroon itself presents a microcosm of some of the fault lines of differences of post-independence British and French involvement in medicine. Thus, beyond the danger of letting a history of international health in India stand in for histories of African countries, the case of India presents crucial differences in its interaction with the WHO due to the time of its independence and the nature of its decolonization.

Turning finally to histories of international health campaigns focused at the level of international institutions, the global malaria and smallpox eradication programs have been

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<sup>31</sup> Sunil Amrith, *Decolonizing International Health: India and Southeast Asia, 1930-65* (New York: Palgrave Macmillan, 2006). Sanjoy Bhattacharya, *Expunging Variola: the Control and Eradication of Smallpox in India, 1947-1977* (New Delhi: Oreint Longman, 2006).

<sup>32</sup> Amrith, 103-104.

<sup>33</sup> Amrith, 106.

closely treated by historians of medicine and yet, relatively little work has been done on these topics by African historians in showing how these campaigns operated at specific local, national or regional levels.<sup>34</sup> This is particularly true in the case of smallpox eradication, on which very little work has been done by historians of Africa. This project adds to the history of these global campaigns through examining new local dynamics, but it also reframes the significance of the programs in Cameroon beyond the stated imperatives of international health institutions. I show that these programs were both part of a longer negotiation about the role of mobile health teams in Cameroon, and about the relationship between colonial, international and national models of rural health intervention.

The second main contribution of this project is that it shows that public health was a key arena of governance through which Africans negotiated new post-independence relationships among African countries, with European powers, and with international institutions. I assert that the focus of international health organizations on disease eradication, and the centrality of colonial mobile health teams and their post-independence reorganization to this agenda, show that health was a vital realm of international negotiation through decolonization and after independence. This claim relates to a broader literature that has highlighted the international dimensions of decolonization and early independence in Africa.

Works on decolonization in Africa have shown that postwar politics in colonial Africa operated on an international stage. Matthew Connelly and Elizabeth Schmidt, for example, have shown in different contexts how the Cold War context served as both a resource and a

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<sup>34</sup> Webb's work on malaria in Africa provides a comprehensive overview of changing strategies, technologies and programs, but it does not focus on how these evolving programs intersected with colonial medical administration or postcolonial politics (2014).

barrier for new African leaders in the pursuit of their own agendas for independence.<sup>35</sup> Some scholars have begun to center health in the international politics of the end of empire in Africa. Jessica Pearson highlights, for example, how France sought to limit the incursion of UN health agencies in Africa in the 1940s and 50s.<sup>36</sup> Jennifer Johnson meanwhile shows that claims on the ability to provide for the health of the Algerian people became central to struggles over sovereignty between nationalists and French during the Algerian war. Algerian nationalists, moreover, leveraged international organizations such as the International Committee of the Red Cross, in this pursuit.<sup>37</sup> Matthew Heaton reveals how Nigerian psychiatrists at independence sought to “transform colonial psychiatric institutions and theories” as part of a broader concern over shaping postcolonial “modernity.” He argues that this pursuit happened through international, cross-cultural avenues.<sup>38</sup> These works show that international politics and international institutions, sometimes through the specific lens of health, were formative of the politics of decolonization in Africa.

In addition to this broader literature, scholars of Cameroon have recently built a body of scholarship that emphasizes the distinctly international politics of decolonization created both through the existence of the UN Trusteeship and the existence and aftermath of dual colonial

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<sup>35</sup> Matthew Connelly, *A Diplomatic Revolution: Algeria's Fight for Independence and the Origins of the Post-Cold War Era* (Oxford; New York: Oxford University Press, 2002). Elizabeth Schmidt, *Cold War and Decolonization in Guinea, 1946-1958* (Athens: Ohio University Press, 2007).

<sup>36</sup> Jessica Pearson-Patel, “French Colonialism and the Battle against the WHO Regional Office for Africa,” *Hygiea Internationals: An Interdisciplinary Journal for the History of Public Health*, 13. 1 (2016): 65-80, accessed January 25, 2017, doi: 10.3384/hygiea.1403-8668.1613165.

<sup>37</sup> Jennifer Johnson, *The Battle for Algeria: Sovereignty, Health Care and Humanitarianism* (Philadelphia: University of Pennsylvania Press, 2016), 2-5.

<sup>38</sup> Matthew M. Heaton, *Black Skin, White Coats: Nigerian Psychiatrists, Decolonization, and the Globalization of Psychiatry* (Athens, Ohio: Ohio University Press, 2013), 5.

administration. This scholarship holds that moving beyond the metropole-colony relationship is essential for understanding decolonization in Cameroon.<sup>39</sup> Meredith Terretta, for example, frames the trajectory of the anti-colonial nationalist party in Cameroon, the *Union des populations du Cameroun* (UPC) as both “particularly local and expansively global” in its mobilization of human rights discourse before the UN and of Pan-Africanism, as well as of local political idioms of sovereignty.<sup>40</sup> From another angle, Mélanie Torrent has focused on Cameroon as a place that uniquely illuminates “transnational, transregional and multilateral histories of decolonisation,” in part because of the joint Trusteeship status that led the French and British into a “conversation that did not occur elsewhere.”<sup>41</sup> These works argue, for different reasons, that Cameroon’s decolonization was inherently and distinctly international.

With regards to health, some scholars have argued that public health can be a way into a “broader conception of international society,” in the Cold War and postwar period, by integrating “attention to state actors with recognition of the role played by international organizations, nongovernmental organizations (NGOs), multinational corporations, and transnational “epistemic communities” that produce, circulate, and deploy expert knowledge.” Erez Manela, in writing specifically about the role of the Smallpox Eradication Program, calls for historians to look not just “beyond the state” at non-state actors, but also “into the state” at

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<sup>39</sup> Meredith Terretta, *Nation of Outlaws, States of Violence: Nationalism, Grassfields Tradition, and State Building in Cameroon* (Athens: Ohio University Press, 2014), 3.

<sup>40</sup> Terretta (2014), 3. See also: Meredith Terretta, “We Had Been Fooled in Thinking that the UN Watches over the Entire World”: Human Rights, UN Trust Territories, and Africa’s Decolonization.” *Human Rights Quarterly* 34.2 (2012): 329-60. Meredith Terretta, “Chiefs, Traitors, and Representatives: The Construction of a Political Repertoire in Independence-Era Cameroun.” *International Journal of African Historical Studies* 43.2 (2010): 227-253. Meredith Terretta, “Cameroonian Nationalists Go Global: From Forest *Maquis* to a Pan-African Accra,” *Journal of African History* 51 (2010): 189-212.

<sup>41</sup> Mélanie Torrent, *Diplomacy and Nation-Building in Africa: Franco-British Relations and Cameroon at the End of Empire* (London: I.B. Tauris & Co, Ltd, 2012), ix.



less commonly studied actors.<sup>42</sup> Calls of looking both “beyond the state” and “into the state” in international history have often focused on American and European states and organizations.

What happens to this view of international history if, instead, we turn our attention to less commonly discussed actors both within and beyond the African state? In this project, I hold that looking at institutions such as the mobile health service in independent Cameroon, and OCEAC, the regional health organization created in Cameroon, can broaden our understanding both of international health and of the international history of decolonization. Moreover, centering health and medicine in international histories of decolonization and independence opens avenues for new perspectives on broader political questions. Medicine and health in Cameroon, for example, became an arena through which other political questions were explored such as new affiliations between independent African states and the navigation of differences in institutions created through the boundaries of European imperialism. The expanse and the boundaries of the French colonial mobile health teams became a way that French and Cameroonian health officials demarcated new parameters of health coordination. I thus approach the demarcation and conceptualization of Cameroon as a national space for medical intervention as something forged in an inherently international way.

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<sup>42</sup> Erez Manela, “A Pox on Your Narrative: Writing Disease Control into Cold War History,” *Diplomatic History* 34. 2 (2010): 299-323. Manela argues that writing the history of the Smallpox Eradication Program into Cold War history requires attention to non-state actors, and thus responds to recent turns in writing about such actors in international history. He also argues, however, that the program requires attention to less commonly discussed state actors such as the American Centers for Disease Control. On the turn to non-state actors in international history, Manela cites: Akira Iriye, *Global Community: The Role of International Organizations in the Making of the Contemporary World* (Berkeley, CA, 2002); Amy L. S. Staples, *The Birth of Development: How the World Bank, Food and Agriculture Organization, And World Health Organization Have Changed the World 1945-1965* (Kent, Ohio, 2006). The call to “see beyond the state” in international history comes from Matthew Connelly, *Fatal Misconception: The Struggle to Control World Population* (Cambridge, MA, 2008). Manela notes that “the phrase ‘seeing beyond the state’ echoes James C. Scott, *Seeing Like a State: How Certain Schemes to Improve the Human Condition Have Failed* (New Haven, CT, 1998).

Finally, this project engages with another body of work that has raised questions about relationships between new-found sovereignties of the postcolonial state in Africa and new forms of international involvement in these states. Gregory Mann, for example, has pointed to the first two decades of independence in the West African Sahel as a time that created “a fertile terrain for the production of new forms of governmental rationality realized through NGOs.”<sup>43</sup> Focusing only on the first decade of independence in Cameroon, this dissertation highlights a distinct historical moment of state-centered development, one that sharply contrasts with a later period of disinvestment in the medical administration of the state. Thus, while it underscores a rising complexity of health actors, the ones examined here are exclusively governmental and intergovernmental organizations. If there is a connection to be drawn between a later burgeoning of NGOs in the face of economic crisis, neoliberal reform, and defunding of state health administration in Cameroon, it is that in the 1960s, multiple governmental bodies—the World Health Organization, the French Ministry of Cooperation, and United States aid agencies--all staked claims in funding health programs and their ensuing agendas produced conflict. Thus, while state medicine in 1960s Cameroon was distinct from later decades, we can see in the first decade of independence how the governance of medicine and public health by the state was inextricably marked by both the post-colonial relationship to France and by the forces of international health. The formation of a state policy or infrastructure of health was shaped deeply, from their inception, by these external forces.

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<sup>43</sup> Gregory Mann, *From Empires to NGOs in the West African Sahel: The Road to Non-Governmentality* (New York: Cambridge University Press, 2015), 2. Mann poses the question of “how at particular moments certain characteristics of government itself began to be defined as beyond the prerogatives of the state.” 5.

## Methodology

This project draws on research in thirteen archival collections in Cameroon, France, Switzerland and the United States. Additionally, I conducted oral interviews with former Cameroonian medical personnel, including nurses and high-ranking government officials. I have thus drawn on a wide variety of sources—from government correspondence, reports of health institutions, Cameroonian newspapers, and oral histories—to bring together local, national and international perspectives.

The sources available for this project and the structure of my research presented both opportunities and limitations. For one, research in archival sites across four countries often created opportunities in unexpected places for glimpses into transnational and international exchange. For example, the archives of the American CDC held important correspondence with OCEAC, the regional organization based in Cameroon, whereas an annex of the national archives in Buea, Cameroon housed bits of correspondence between Cameroonian medical personnel and CDC officials. Each chapter draws from archives in multiple sites and thus no part of the project would have been possible without this multi-sited work. This methodology in itself reflects the ‘global’ and ‘local’ tensions of this dissertation, of moving between the World Health Organization archives and those of Buea, for example. It is a central claim of this dissertation that global health history told only at the scale of the ‘global,’ from both the perspective of framing and of methodology will inevitably obscure the specificities of local, national and regional histories. While this claim is not in itself new, the logistical challenges for historians of Africa wishing to do this kind of archival work can be numerous. I hope that this work thus suggests some of the ways that multi-sited research can be used to examine histories of global health after independence in Africa.

Cameroonian governmental archives on public health in the 1960s are extremely limited in the National Archives in Yaoundé. I overcame this limitation, in part, through work in smaller archival collections in Cameroon and through looking at conference proceedings and reports of the regional organization, OCEAC. The ability to capture additional layers of discord and negotiation behind closed doors is limited by sources such as conference proceedings.<sup>44</sup> However, these sources do lay bare very clear tensions that offer a new narrative of the post-independence negotiation of international health in Cameroon. Moreover, while I draw on select oral histories with former medical personnel, I do not focus primarily on the lived experience of Cameroonians who were the targets of these campaigns. There are certainly a multitude of stories to be told in this regard. My interest, however, is primarily in questions of authority, expertise and planning for medicine and health between colonial, national and international health officials.

## Chapter Outline

This project traces the negotiation between Cameroonian, French, and international health officials over mobile health teams as a basis for public health intervention through key political and public health developments between 1945 and 1970. This timeframe marks a period of postwar public health reform that continued across the colonial/postcolonial divide, as well as the duration of the ‘eradication era’ in Cameroon.<sup>45</sup> As the smallpox eradication

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<sup>44</sup> Sanjoy Bhattacharya recommends as one method for writing global histories of health and medicine of “going behind the scenes to study views expressed in private, and then assess how the resulting convictions, discussions, and debates impacted on the unfolding of policy.” Sanjoy Bhattacharya, “Global and Local Histories of Medicine: Interpretative Challenges and Future Possibilities,” in *The Oxford Handbook of the History of Medicine*, ed. Mark Jackson (New York: Oxford University Press, 2011), 137.

<sup>45</sup> This periodization more broadly reflects the “rise of the developmentalist state” in Africa, from 1940-1973, and the crisis of this state formation from 1973-90. Frederick Cooper has argued that this periodization captures

program in Cameroon concluded successfully at the end of the 1960s, this time also marked a point of departure as health officials in Cameroon began to re-envision the medical administration in light of the failures of malaria eradication.

Chapter 1 shows how global malaria eradication efforts in the 1950s in Cameroon worked through and relied on French colonial mobile health teams. Moreover, it was through the engagement of the mobile health teams with international organizations that French officials created and safeguarded roles as local implementers of international health programming.

Chapter 2 examines how Cameroonian and French health officials used the mobile health team service as the basis for the creation of a new regional health organization after independence, bringing together Cameroon and the four states of former French Equatorial Africa as members. I argue that Cameroonian and French health officials ultimately used mobile health teams to pursue a political vision for cross-border public health after independence that was rooted in the geography of French empire and sought to assert an alternative forum for health coordination to that advanced by the World Health Organization Regional Office for Africa.

Chapter 3 focuses on how Cameroonian doctors and political officials negotiated the dual legacy of colonial medicine in light of the unification of the former British and former French territories to form the independent state. I argue that, while French models of medical administration ultimately dominated national health policy, medical officials and patients in West Cameroon pushed back against this development. Work by francophone Cameroonian officials to extend the French mobile health system to West Cameroon serves as a central case study of these broader debates over boundaries of medical administration and influence.

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economic ruptures that political independence does not. Frederick Cooper, *Africa Since 1940: The Past of the Present* (Cambridge: Cambridge University Press, 2002), 87.

Chapter 4 analyzes the first major global health campaign after independence: the global smallpox eradication program. Cameroonian and French health officials insisted that the program operate within the framework of the new regional health organization in Cameroon and through the existing mobile health team structure. This arrangement demonstrated how the mobile health teams continued to provide infrastructure for global disease eradication programs, but also worked through reformulated politics on a regional scale between African states and with French medical officials.

Chapter 5 shows how Cameroonian health officials began to work in the 1960s with the World Health Organization to develop a new model for public health administration that integrated the mobile health team system into a more comprehensive plan for rural health. This chapter reveals how broader debates of international health—rooted in the ultimate failure of malaria eradication and the prioritization of a turn towards basic health services—became grounded in debates about the role of the mobile health teams and ultimately, the preservation of colonial medical systems.

## Chapter 1: Medical mobility and the Politics of Malaria Eradication in Colonial Cameroon

In 1952, Italian Dr. Emilio Pampana, director of the World Health Organization's malaria unit, traveled to the French colonial territories of Haute Volta and Cameroon to observe the work of the colonial mobile health team service, known in Cameroon as the *Service Général d'Hygiène Mobile et de Prophylaxie* (SHMP).<sup>46</sup> Pampana spent half a day observing a SHMP team work in Mbalmayo, Cameroon a town thirty miles south of the capital, Yaoundé. He reported:

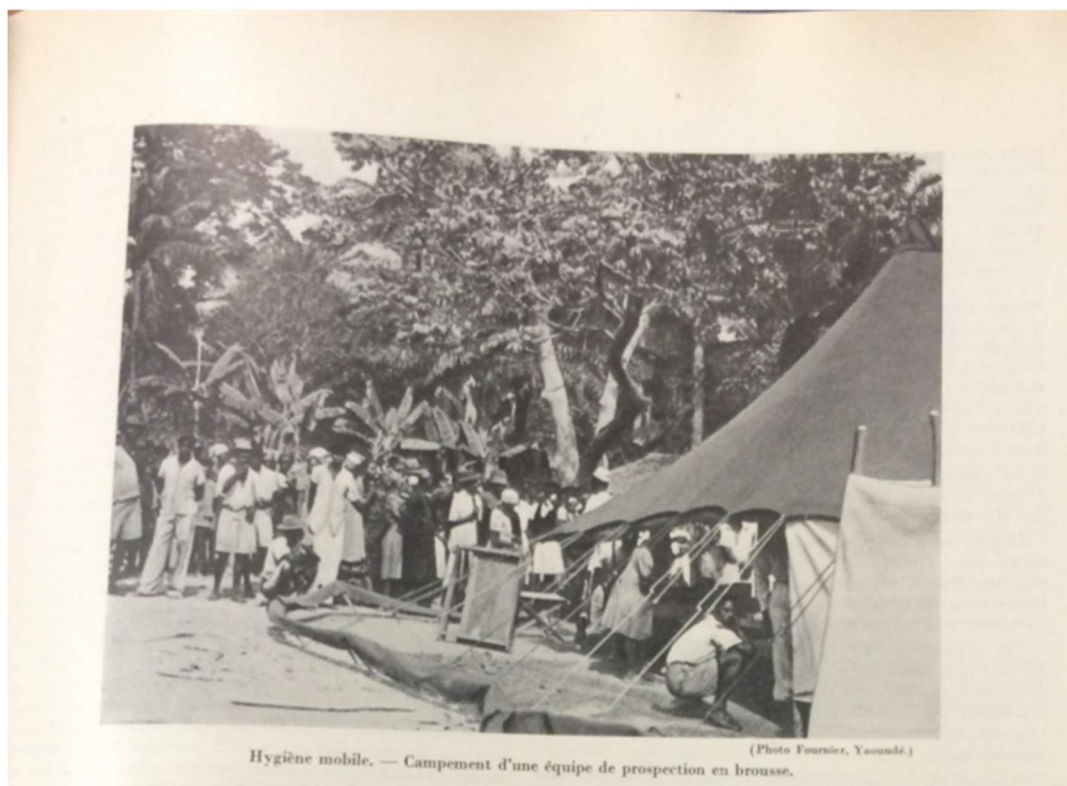
At seven o'clock am, the personnel of the team performs mass immunizations (smallpox and yellow fever, a mixed vaccine, by scarification)... Later in the day, i.e. about eight o'clock, when the higher temperature might interfere with the maintenance of the vaccines emulsion, immunizations are interrupted for the day and the people are directed to the Prospecting team tents. Men on a queue, women on another, each leading to, and progressing towards, a census table, where blood specimens are taken, numbered with the number that the individual had on the census list. Hence every individual passes into a cubicle where he, or she, undresses entirely and is carefully examined, not only for enlarged lymph glands, leprosy lesions or cutaneous lesions of any nature, but also...as regards venereal diseases. This examination includes inspection of the genitalia and the making of slides wherever discharge is seen. Female nurses attend the women.

Every subject suspected of trypanosomiasis, leprosy, yaws or VD is marked with chalk and on his or her leaving the examination cubicle, is asked to wait in the microscopists' tent. There are some ten 'Infirmiers' who puncture the enlarged lymph gland of the subjects marked for that purpose and examine the fluid and the blood; they also examine urethral discharges of the others and inform the doctors of the results.<sup>47</sup>

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<sup>46</sup> In French West Africa, the mobile health team service went by the acronym SGHMP, the *Service Général d'Hygiène et de Prophylaxie*. On Pampana as first director of the WHO's malaria unit: Nancy Leys Stepan, *Eradication: Ridding the World of Disease Forever?* (Ithaca, NY: Cornell University Press, 2011).

<sup>47</sup> Archives, *Service historique de la Défense*. Toulon, France (SHD), SHD 2013 ZK 005 101. "Note on the 'Service Général d'Hygiène Mobile et de Prophylaxie (SGHMP) of French West Africa." Prepared by Dr. E.J. Pampana after his recent visit to Africa, September 1952. Pampana goes on to describe the lomidine injections that those individuals whose lymph gland or blood showed trypanosomes, and the practice of giving lomidine injections prophylactically to inhabitants twice per year.



SHMP team village visit. *Rapport Annuel du Gouvernement Français aux Nations Unies sur l'Administration du Cameroun Placé sous la Tutelle de la France, 1948.*

Pampana continued with admiration for the efficiency of this invasive work:

It is surprising to see how smoothly the machine is working, how silently, orderly and regularly the rural population flows through the prospecting teams, how docile it looks, without protesting against the long queues, or objecting to the various medical technicalities, some of which are certainly not very pleasant, like the puncture of the cervical lymph-glands or the lumbar puncture....there is probably no better example of an organization of control of the major communicable disease in underdeveloped countries in Africa.

He noted that, although the mobile team service, both in Cameroon and in French West Africa, had done 'practically nothing' so far to combat malaria, colonial officials were ready to focus efforts of the mobile service on malaria control. Reflecting on how this colonial health service would play a role in the World Health Organization's malaria eradication efforts, he concluded,



“It is a good coincidence that the pilot projects in the Haute Volta and the Senegal will be carried out by the SGHMP and in the Cameroons, by the SHMP.”<sup>48</sup>

Pampana’s visit to the French colonial mobile health teams as a World Health Organization observer illustrated formative changes to public health work in Africa after World War II. On the one hand, as France emerged from World War II, it laid out a series of political and social reforms for its empire in Africa, including investments in and expansion of its medical administration. This reformist vision included the goal of expanding the mission and the capacity of the mobile health team service, which had drastically lowered sleeping sickness rates in Cameroon and Equatorial Africa in the interwar period. On the other hand, the postwar period brought the creation of the United Nations and its specialized health agency, the World Health Organization (WHO), which would play an increasing role in defining health agendas in colonial Africa. In the 1950s, the WHO would notably spearhead the global malaria eradication program, the first program to strive for eradication of a disease on a global scale. In the context of this ‘global’ campaign, however, the WHO took a tentative approach to combatting malaria in Africa and began with only a series of pilot projects across the continent.

Cameroon became a central site in the development of these intersecting changes to international organizations, public health, and empire in Africa. First, Cameroon occupied a key place in the creation and development of the French mobile health team service, which this chapter will discuss further. After World War II, with the creation of the United Nations and designation of French Cameroon as a Trusteeship under French administration, Cameroon moreover became a place politically defined simultaneously by European colonial rule and the

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<sup>48</sup> SHD 2013 ZK 005 101. “Note on the ‘Service Général d’Hygiène Mobile et de Prophylaxie (SGHMP) of French West Africa.” Prepared by Dr. E.J. Pampana after his recent visit to Africa, September 1952.

new postwar international order. In the 1950s, Pampana, the WHO malariologist, also advised that Cameroon become a specialized site for research into the use of residual insecticides for combatting malaria in Africa.<sup>49</sup> With support from the WHO and UNICEF, French Cameroon launched pilot programs for malaria eradication in both the north and south, and established a specialized site of research, an ‘international pilot zone’ near Yaoundé, to test methods that could be scaled up in other areas of Africa.

The malaria program in Cameroon brought only a handful of World Health Organization technical personnel to the territory over the course of the 1950s, and it relied on the ground on the French colonial mobile health service. French military doctors ran this mobile health service, while Cameroonians constituted the vast majority of its work force. This chapter examines the relationship of the mobile health service to the malaria program in the 1950s, asserting that this program reveals the creation of new postwar relationships of colonial medicine and international health. While the malaria program in Cameroon existed as part of an international health agenda and the research conducted there had broader implications, on the ground it was an extension of the work of the colonial mobile health teams. I argue that this arrangement had implications for the practice of colonial mobile health teams, for the work of international health, and for the Cameroonians who were the targets of these interventions. First, French doctors and officials asserted the mobile health team service as providing a structure as well as a form of local expertise of particular value to the pursuit of disease eradication programs. In turn, international health officials conducting research in Cameroon on malaria relied in key ways on knowledge and practices generated by the mobile health teams—

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<sup>49</sup> Morin, H.G.S., « Sur une campagne antipalustre au Cameroun (1953-1954), *Rivista di Malariologia* 34 (1955) : 39.

about the Cameroonian people, about the environment, and about the way to gain access to both for scientific study or medical intervention. Thus while the WHO and UNICEF provided some of the resources for the program, they also relied deeply on the existing capacity of the colonial medical service. Lastly, because the malaria program worked through the mobile teams, Cameroonians thereby experienced this first major postwar international health program as part of the mobile health service, which carried with it the weight of complex localized histories of medical success in combatting sleeping sickness, but also coercion and violence. The malaria eradication program—both those programmatic components run directly by mobile health teams and those that involved international health personnel— therefore developed within the existing parameters of colonial medicine.

The merger of this international health agenda and the colonial mobile health teams came together through an aspiration of medical mobility, represented by the goal of accessing the rural Cameroonian population as targets of public health intervention. In the study of medicine and health in Africa, scholars have pointed to the centrality of “mobility as an effect of power,” and as a concept that helps to account for the importance of the movement of African healers, of international experts, of patients, medications and technologies.<sup>50</sup> In this chapter, I focus on this investment in the goal of medical mobility as a particular postwar convergence of operational philosophy between colonial medical officials and the newly created institutions of international health.

This convergence on one hand reflected the broader post-war turn of colonial governments and new international institutions towards ‘development’ as a framework for

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<sup>50</sup> Stacey A. Langwick, Hansjörg Dilger, and Abdoulaye Kane, “Introduction: Transnational Medicine, Mobile Experts,” in *Medicine, Mobility, and Power in Global Africa*, ed. Hansjörg Dilger et al. (Bloomington: Indiana University Press, 2012), 1-2.

action.<sup>51</sup> The new postwar international institutions of the United Nations, including the WHO, championed the idea of intervening in Africa, Asia and Latin America through foreign aid, economic planning and transfers of technology, all in the name of bringing the economies of these places in closer alignment with those of wealthier ‘developed’ countries.<sup>52</sup> French and British colonial governments likewise undertook major development initiatives with the hope that they would create stronger colonial economies as well as help to secure colonial rule in the face of political pressures being exerted by Africans in the postwar period.<sup>53</sup>

In the postwar period, international health institutions meanwhile began to champion the idea of disease eradication as the central paradigm for their work. Disease eradication as a public health strategy reflected the central premise of postwar development in that it relied on “techno-scientific solutions to social problems.”<sup>54</sup> The wartime production of DDT, an insecticide proven to have powerful effects in protecting troops against malaria, spurred new hope in the possibilities for its widespread application as a tool of malaria eradication. Cold War rivalry, and the dominance of the United States in the WHO, and the UN at large,

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<sup>51</sup> Randall Packard, “Visions of Postwar Health and Development and Their Impact on Public Health Interventions in the Developing World,” in *International Development and the Social Sciences: Essays on the History and Politics of Knowledge*, ed. Frederick Cooper and Randall Packard (Berkeley: University of California Press, 1997), 93.

<sup>52</sup> Frederick Cooper and Randall Packard, introduction to *International Development and the Social Sciences: Essays on the History and Politics of Knowledge*, edited by Frederick Cooper and Randall Packard (Berkeley: University of California Press, 1997), 2. Amy Staples writes on the concept of development as a cause for the institutions of the United Nations, although she adopts an uncritical stance towards the political context of these agencies and their officials. Amy Staples, *The Birth of Development: How the World Bank, Food and Agriculture Organization, and World Health Organization Changed the World, 1945-1965* (Kent, Ohio: Kent State University Press, 2006).

<sup>53</sup> Frederick Cooper, “Modernizing Bureaucrats, Backward Africans, and the Development Concept,” in *International Development and the Social Sciences: Essays on the History and Politics of Knowledge*, edited by Frederick Cooper and Randall Packard (Berkeley: University of California Press, 1997), 64.

<sup>54</sup> Stepan, 106. Stepan provides a history of the eradication idea in the early 20<sup>th</sup> century as well as more fully exploring why it became a key strategy in the postwar period.

moreover greatly influenced this turn towards technical approaches to health and the investment in the eradication idea.<sup>55</sup>

After World War II, French colonial officials likewise formulated visions for disease eradication within colonies, targeting sleeping sickness, which had been a major scourge and focus of concern in the African colonies, particularly in Cameroon.<sup>56</sup> French colonial officials pursued sleeping sickness campaigns most aggressively within Cameroon, in part due to its status as a historic site for the development of the mobile health teams and to its status as an ‘international colony.’<sup>57</sup> Many scholars and public health professionals have criticized global disease eradication programs for being ‘vertical’ health programs, meaning that they focused singularly on one disease and did not help build sustainable health systems. Scholars of French colonial medicine have meanwhile noted that the mobile health service was already implementing this kind of ‘vertical programming’ through its intensive sleeping sickness campaigns from the interwar period forward.<sup>58</sup> Less understood is how the mobile health service became directly involved in the implementation of the campaigns of global disease eradication programs.

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<sup>55</sup> Stepan, 119-123. Randall Packard, “No other logical choice’: global malaria eradication and the politics of international health in the post-war era.” *Parassitologia* 40 (1998): 217-28. Socrates Litsios, “Malaria Control, the Cold War, and the Postwar Reorganization of International Assistance,” *Medical Anthropology* 17 (3) (1997): 255-78. Randall Packard, “Malaria Dreams: Postwar Visions of Health and Development in the Third World,” *Medical Anthropology* 17 (3) (1997): 279-96.

<sup>56</sup> Guillaume Lachenal, *Le Médicament qui devait sauver l’Afrique : Un scandale pharmaceutique aux colonies* (Paris : La Découverte, 2014), 57-101.

<sup>57</sup> Lachenal (2014), 78.

<sup>58</sup> Josiane Tantchou, *Épidémie et politique en Afrique : Maladie du sommeil et tuberculose au Cameroun* (Paris : L’Harmattan, 2007), 58. Lachenal (2014), 82-83.

Although the French mobile health service and the WHO identified different targets for eradication in Africa, both visions depended on the premise of reaching and intervening in the lives of people living in rural areas. In Cameroon, and elsewhere in the French empire in Africa, the colonial mobile health service ultimately realized this international health goal on the ground in the 1950s. This system of public health in rural Africa thus became the operational basis for malaria eradication programs in the 1950s. The mobile teams solidified a practice of rural public health intervention as an *event* for intended recipients, which would take place in discreet times and places, with these parameters established by people external to the communities in which they operated. Mobile teams, usually led by a European doctor but constituted almost entirely of African workers, would appear in a village, perhaps once per year, to administer smallpox vaccinations or give lomidine injections. Then they would leave. The service moreover developed its own localized histories of coercive and punitive measures to try to ensure compliance. The model of the mobile health teams, already established in the interwar period in Cameroon, but expanded after World War II, thus greatly facilitated the new WHO goals of campaign-style eradication efforts. Those WHO personnel who worked in Cameroon turned to the mobile teams for ideas about the most efficient ways to travel to villages and operate within them. They worked closely with the mobile health team service and the other colonial medical officials, and ultimately their work as ‘international health officials’ became indistinguishable on the ground from the broader colonial medical operation.

This micro-study of the malaria program in Cameroon points to a broader negotiation between colonial powers and international organizations over health in the postwar period. As recent scholarship has shown, French colonial officials often resisted the interference of the World Health Organization and other UN agencies in postwar Africa, while at the same time

welcoming the new resources made available through these channels to fund health administration in the colonies.<sup>59</sup> While these works shows how metropolitan governments negotiated the creation of new international health institutions and programs and their potential threats to colonial medicine, I shift focus to how the convergence of international health agendas and colonial medical administration operated on the ground. This relationship is critical for understanding how French colonial medicine in Africa became part of international health in the postwar period (and vice versa) and, in turn, how Africans experienced the first efforts of global disease eradication.

Moreover, colonial officials in Cameroon drew important forms of political capital from the opportunities and resources created by international health organizations during a volatile political time. Against the backdrop of a growing anti-colonial political uprising in the mid-1950s and debate over Cameroon's Trusteeship status, French officials used the malaria eradication program to argue that their work in Cameroon contributed to the pursuit of international health and thus to defend their ongoing control of this work. The French doctors of the mobile health team service in turn created roles as local experts and implementers of international health programming, rooted in the particular moment of disease eradication. As Cameroonians gained more political (and medical) authority in the late 1950s and through independence, these doctors effectively guarded this arena as one over which they claimed exclusive control. The malaria program thus forged relationships of colonial and international health that became formative to the operations of international health in the state when

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<sup>59</sup> Jessica Pearson-Patel, *From the Civilizing Mission to International Development: France, the United Nations, and the Politics of Family Health in Postwar Africa, 1940-1960* (Dissertation, New York University, 2013). James A. Gillespie, "Europe, America, and the Space of International Health," in *Shifting Boundaries of Public Health: Europe in the Twentieth Century*, ed. Susan G. Solomon, Lion Murard, and Patrick Zylberman (Rochester, NY: University of Rochester Press, 2008): 114-37.

Cameroon first became independent. Subsequent chapters will examine how the reorganization of the mobile health team service after independence in turn continued to be central to the formation of international health in Cameroon.

This chapter begins by explaining the origin of the French mobile health service in Cameroon, before examining how the mobile teams shaped the advent of malaria eradication programs in the 1950s. During this time, health officials and personnel involved in these campaigns created new operational structures and a new politics of international health in a colonial space.

### **French Mobile Health Teams in Cameroon**

The postwar mobile health teams that became so critical to disease eradication programs originated in the interwar period in French efforts to curb a sleeping sickness epidemic raging in Cameroon and French Equatorial Africa. Postwar reforms transformed the mobile health service, from one focused exclusively on sleeping sickness, into a multipurpose service that continued to focus largely on sleeping sickness but to also include other endemic and epidemic diseases, such as smallpox and leprosy. This section will sketch an overview of how the French military medical corps developed the mobile teams as a distinct medical service within Cameroon and across the French empire in Africa, as well as describing how these teams functioned on the ground. Although writing on French colonial medicine has extensively examined the establishment of the mobile teams—both hagiographies and histories of creator Eugène Jamot's work in Cameroon and beyond abound--this section will describe in some detail the way this work unfolded in rural settings in Cameroon.<sup>60</sup> The dynamics developed within the

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<sup>60</sup> On Jamot: Noémi Tousignant, « Trypanosomes, Toxicity and Resistance: The Politics of Mass Therapy in French Colonial Africa, » *Social History of Medicine* 25, no. 3 (2012): 625-643. Jean-Paul Bado, *Eugène Jamot*,



teams, between French colonial doctors and Cameroonian auxiliaries, and between the teams and rural populations would have far-reaching impact, beyond the strict confines of French-funded medical endeavors, and beyond the colonial period.

The model for the French mobile health service developed in the interwar period in the context of efforts to address a growing sleeping sickness epidemic in Cameroon and in territories of French Equatorial Africa. At this time, the French had only recently taken possession of part of the German territory of Cameroon, with the end of World War I. The new League of Nations Mandate system established two new territories out of German Cameroon; both would be ‘Mandates’ under the League, one under British administration and the larger territory under French administration.

When the French took over Cameroon, medical administration in the territory developed through the implementation of the *Corps de Santé Coloniale*, the medical arm of the French colonial military troops. Doctors in this service held positions that straddled the line between military and civilian service. They undertook specialized training at the *École de Santé Navale de Bordeaux* and *L’École d’Application du Service de Santé des Troupes Coloniales* in Marseille, and although officially part of the *Troupes Coloniales*, they served under a special designation marking their largely civilian function.<sup>61</sup> That said, the military framework for the service deeply marked its professional ethos.

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1879-1937 : *Le Médecin de la maladie du sommeil ou trypanosomiase* (Paris : Éditions Karthala, 2011). Guillaume Lachenal and Bertrand Taithe, « Une généalogie missionnaire et coloniale de l’humanitaire : Le cas Aujoulat au Cameroun, 1935-1973, » *Le mouvement social* 227, no. 1 (2009) : 45-63. In the category of hagiographies : Léon Lapeyssonnie, *Moi Jamot, le vainqueur de la maladie du sommeil* (Brussels : Éditions Louis Musin, 1987). Marcel Bebey-Eyidi, *Le Vainqueur de la Maladie du Sommeil : le docteur Eugène Jamot* (Paris : M.B. Eyidi, 1950)

<sup>61</sup> The doctors’ status was ‘hors-cadre’ in the *Troupes Coloniales*. Tantchou (2007), 52.

Dr. Eugène Jamot of the *Corps de Santé Colonial* played an immense role in shaping this ethos and the idea of a distinct French colonial medicine through his formation of the mobile health team model. Jamot first created the mobile team model through his work in Oubangui Chari (present-day Central African Republic) in 1917 in addressing the growing epidemic of sleeping sickness. In an effort to curb the further spread of the disease, Jamot worked within a designated ‘sector’ in central Oubangui Chari, and sought to examine as many as people as possible within that geographic space, giving atoxyl injections to eliminate the parasite within those diagnosed.<sup>62</sup> In practice in Ubanguï-Chari, the threshold for giving injections to only those with an identified parasite broke down, and medical personnel gave atoxyl injections to anyone ‘suspected’ of carrying the parasite, often based on visual features such as swollen neck glands. Rather than focusing on the illness of the individual, Jamot insisted on the need to protect the ‘collectivity.’<sup>63</sup>

In addition to this turn towards focus on the collective, the great novelty of Jamot’s approach within the French colonial medical service was the idea that, rather than colonial doctors waiting for sick patients to arrive to them, those doctors should travel directly to people. Jamot, and the other military doctors who formed the corps of this service, imbued this mobility

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<sup>62</sup> For a description of these early attempts, see Rita Headrick, *Colonialism, Health and Illness in French Equatorial Africa, 1885-1935*, ed. Daniel R. Headrick (Atlanta: African Studies Association Press, 1994), 346-347. The cure of the individual patient in this process was sometimes a byproduct of the medication given, atoxyl, but the focus was on preventing the further spread of the disease. As Headrick explains, the focus ‘remained on the collectivity, not the individual patient.’ After graduating from medical school in Montpellier, Jamot joined the French colonial health service in 1909, serving in Chad with the French forces, followed by study at the Pasteur Institute in Paris, and a posting at the Pasteur Institute in Brazzaville. During World War I, he worked as the head doctor for French forces advancing in Cameroon, then under German colonial rule. In 1916, he became the director of the Pasteur Institute in Brazzaville. Headrick, 346.

<sup>63</sup> Headrick 349.

towards the sick with a distinctly militaristic tone. One French colonial doctor summarized Jamot's approach:

First of all Jamot calls upon an essential military virtue: the offensive. You must not passively await the blows that the disease inflicts at random on the population, but must on the contrary carry the fight to the very heart of the epidemic. The terminology of this resolutely offensive health strategy is transparently military: the country is divided into sectors, massive campaigns are launched with their successive phases of geographic reconnaissance, attack, consolidation, and surveillance...<sup>64</sup>

After Jamot's methods proved effective in lowering the number of sleeping sickness cases in French Equatorial Africa, he transported this model to French Cameroon, where people in the south were experiencing a major sleeping sickness outbreak.<sup>65</sup> In 1926, Jamot's work in Cameroon culminated in the creation of a distinct medical service: *La Mission Permanente de Prophylaxie de la Maladie du Sommeil* (MPMS), comprised of 11 doctors, 20 European sanitary agents, and 150 Cameroonian nurses.<sup>66</sup> By 1931, the service had increased to include 400 Cameroonian medical auxiliaries.<sup>67</sup> With Jamot as its director, the service functioned independently from the main branch of the colonial medical service, *l'Assistance Médicale aux Indigènes* (A.M.I.).<sup>68</sup> The French investment in Jamot's work in Cameroon reflected concerns about preserving an able African work force in the colonies, but it also reflected inter-imperial

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<sup>64</sup> Lapeysonnie (1972), 35-36, cited in Headrick, 346.

<sup>65</sup> Headrick, 351.

<sup>66</sup> E. Jamot, « La Maladie du Sommeil au Cameroun, » *Journal of the International African Institute*, Vol. 3 No. 2 (1930): 165.

<sup>67</sup> Jean Suret-Canale, *French Colonialism in Tropical Africa, 1900-1945*, trans. Till Gottheiner (London : C. Hurst & Company, 1971), 409. By 1931, there was also an increase to 18 doctors and 36 European agents.

<sup>68</sup> Wang Sonne. *Les Auxiliaires Autochtones dans l'Action Sanitaire Publique au Cameroun sous Administration Française, 1916-1945* (Université de Yaoundé, Faculté des Lettres et Sciences Humaines, Département d'Histoire, Thèse présentée en vue de l'obtention du Doctorat de 3<sup>ème</sup> cycle en Histoire, 1983), 60.

rivalries growing out of World War I and the ensuing loss of control of Cameroon by Germany. Through facilitating the formation of this service and channeling increasing resources towards it, the French colonial government bolstered itself against political attacks by Germany, which claimed that the new mandate power of its previous colony was not performing well.<sup>69</sup>

For Cameroonians, the creation of the first mobile health teams focused on sleeping sickness created new avenues of encounter with colonial medicine. Expanding the work of colonial medicine beyond towns such as Douala and Yaoundé, the teams had the potential to be the dominant, if not the only, experience of colonial medical intervention for many Cameroonians, particularly in the earlier decades of French colonial rule.<sup>70</sup> The formation, travel, and work of the teams moreover created new systems for how medical work occurred. A typical mobile team would consist of one French military doctor, along with anywhere from 30-40 Cameroonian personnel. This included nurses tasked with a variety of specific tasks such as taking blood, giving injections, and doing administrative work. Porters would carry equipment, baggage, and medication. The team would travel 12-15 miles by foot per day, with the overall tour of a team lasting two to three months. The medical work itself proceeded in an ‘assembly-line,’ with sections devoted to medical examinations, screening for sleeping sickness and other diseases, and treatment, through which villagers would pass. Nurses would mark those

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<sup>69</sup> Jean Suret-Canale, *French Colonialism in Tropical Africa, 1900-1945*, trans. Till Gottheiner (London : C. Hurst & Company, 1971) , 409. Suret-Canale documents the increase in funding for Jamot’s service in Cameroon: “Credits appropriated amounted to 10,700,00 francs in 1929 (more than one-sixth of the revenue of the Cameroons), 14,590,000 in 1930 (with a 3,000,000-franc subsidy from France), and 15,900,00 in 1930.

<sup>70</sup> Pamela Feldman-Savelberg, *Plundered Kitchens, Empty Wombs: Threatened Reproduction and Identity in the Cameroon Grassfields* (Ann Arbor: University of Michigan Press, 1999), 145-148. Feldman-Savelberg writes that for ‘the greater part of French rule,’ the only experience of colonial health care in Bangangté, a Bamiléké kingdom in the Grassfields, were the mobile health teams. A Protestant mission in the area did provide biomedical care. The French colonial government built a dispensary in the area in the late 1930s or early 1940s.

diagnosed with sleeping sickness on the chest with a mark of ‘T++’ and would later administer them a series of injections of atoxyl.<sup>71</sup>

With this new geographic reach of colonial medicine, Cameroonian traditional authorities became essential ‘intermediaries’ between the mobile teams and the populations they visited.<sup>72</sup> After receiving notice in advance of the place and time when the mobile team would visit, village chiefs would be responsible for assembling people for the arrival of mobile teams, as well as helping to prepare the work site, housing and food for the teams.<sup>73</sup> Those chiefs who did not comply, and who did not enforce the compliance of their people, were subject to arrest. Guards and police often accompanied mobile teams on their visits for this purpose.<sup>74</sup> The mobile health teams thus employed broader colonial practices of coercion and enforcement, similar to those used for purposes such as labor recruitment and tax collection.

The recruitment and training of Cameroonian medical auxiliaries to work on the teams meanwhile carved out a new social group. From its beginning in the interwar period, the formation of a cadre of Cameroonian medical auxiliaries working for the French colonial medical administration created new divisions between those workers and the rest of the population. In 1921, French officials established a training center in Ayos, Cameroon specifically to train medical auxiliaries for work on the sleeping sickness teams. After following a three-month training course, the first auxiliaries graduated in June 1921.<sup>75</sup> Beginning in 1932,

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<sup>71</sup> The ‘T’ denoted the scientific name for sleeping sickness, trypanosomiasis.

<sup>72</sup> Sonne (1983), 271.

<sup>73</sup> Sonne (1983) 271.

<sup>74</sup> Sonne, (1983) 270. Sonne cites an instance of the chief of a village in the Akonolinga subdivision being arrested in 1930 for having openly encouraged people to flee from the mobile teams.

<sup>75</sup> Sonne (1983), 117.

the *Centre d'Instruction Médicale d'Ayos* began to offer a longer and more comprehensive course of study leading to the title of “aide de santé” or “infirmier brevetés.”<sup>76</sup> Medical auxiliaries were able to expect a regular salary, to use the French language for professional purposes, and to wear a uniform marking their status. By entering in the medical corps, they thus began to live a life of different markings than the vast majority of Cameroonians living in rural areas.<sup>77</sup> The work of the mobile teams brought these new social stratifications into stark relief in the setting of the village visit.

The work of the teams in the villages frequently relied on practices of coercion and punishment. As agents of the colonial administration, medical auxiliaries enforced colonial law, sometimes violently, against those who fled or hid from the medical visit, as well as those working as indigenous healers. The auxiliaries also took direct roles in punishing chiefs who did not facilitate their work.<sup>78</sup> For these reasons, historian Jean Suret-Canale characterized the work of Jamot's teams in Cameroon as “typically colonial.” Suret-Canale compared the methods used to assemble people and undertake their medical interventions as closely aligned with “those used for civil or military recruitment; in other words, they were like “man-hunts.” Moreover, some teams exploited villages in “good colonial fashion...demanding food and

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<sup>76</sup> Sonne (1983), 190-225. The *Ecole d'aides de santé et d'agents sanitaires indigènes* became part of the *Centre d'Instruction Médicale d'Ayos*. The new course of study focused not just on sleeping sickness, but on other diseases such as smallpox, tuberculosis and leprosy. *Infirmier brevetés* studied for two years. *Aide de santé* followed a three-year course of study. The school graduated 58 *aides de santé* between 1932-1944. These more highly trained medical personnel were generally assigned to medical posts, rather than to work on the mobile teams.

<sup>77</sup> Sonne (1983), 267-268.

<sup>78</sup> Sonne (1983), 287-289.

women.”<sup>79</sup> Coercion, however, was not the only form of violence enacted by the mobile health teams. They also enacted invasive medical procedures, which sometimes resulted in disability or death. In the most infamous, in Bafia, Cameroon, a subordinate of Jamot accidentally administered an overdose of the new drug tryparsamide and blinded between 700-900 people.<sup>80</sup>

This brief review of the often-violent impact of the sleeping sickness teams should not obscure, however, the extremely powerful legacy that Jamot left in Cameroon. The success of the mobile teams in drastically lowering the rates of sleeping sickness in southern Cameroon and the professional ethos forged through a distinct militaristic model of confronting epidemic disease in rural areas ultimately transformed the French colonial medical service. Generations of French medical officers and Cameroonian medical personnel hailed Jamot as a hero. In 1951, a Cameroonian doctor, Dr. Marcel Bebey-Eyidi, wrote a tribute to this work entitled ‘The Conqueror of Sleeping Sickness.’<sup>81</sup> In Cameroon, the term ‘Jamotain,’ designating people who worked on the mobile teams, became a badge of professional honor within medicine.<sup>82</sup> In 1959, mere months before French Cameroon became independent, French and Cameroonian officials held a joint ceremony to place a statue of Jamot in front of the Ministry of Public Health in

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<sup>79</sup> Jean Suret-Canale, *French Colonialism in Tropical Africa, 1900-1945*, trans. Till Gottheiner (London: C. Hurst & Company, 1971), 409. Sonne, by contrast, acknowledges the existence of such exploitative and violent occurrences, but disputes this characterization of all of the Cameroonians engaged in the service as a whole.

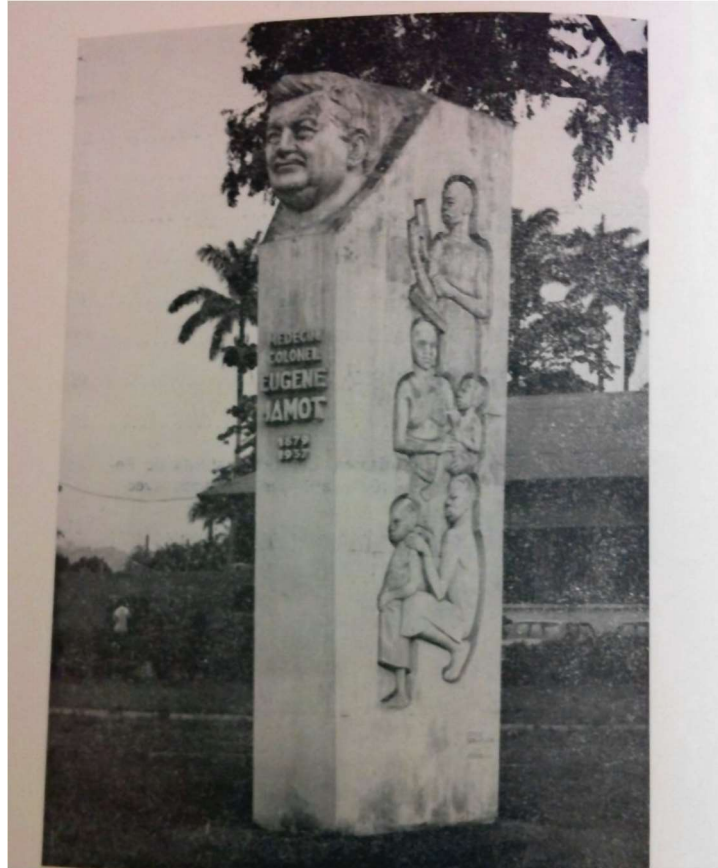
<sup>80</sup> Jamot faced punishment for this event, but it ultimately did not color his legacy within the French colonial medical service. Tousignant writes about how hagiographic accounts of Jamot handle the story of Bafia: Tousignant (2012), 630-636.

<sup>81</sup> Marcel Bebey-Eyidi, *Le Vainqueur de la Maladie du Sommeil : le docteur Eugène Jamot* (Paris : M.B. Eyidi, 1950). « Cinquantenaire de la Mort de Jamot » *Le Bulletin de Liaison et de Documentation* 85 (1988) : 1-81.

<sup>82</sup> Wang Sonne, “Des Camerounais dans la Lutte Contre la Maladie du Sommeil : Les Premier « Jamotains » 1921-1931, » *Le Bulletin de Liaison et de Documentation* 85 (1988) : 27-38. Sonne explains that the name ‘Jamotain’ also applies widely to all medical personnel across former French Africa who upheld Jamot’s spirit and continued his work.

Yaoundé.<sup>83</sup> In 1987, French and Cameroonian medical officials and researchers gathered for a three-day conference in Yaoundé to commemorate the fiftieth anniversary of Jamot's death.<sup>84</sup>

To this day, the bust of Jamot sits in front of the Ministry of Public Health in Yaoundé.



Statue of Jamot in Yaoundé.

SHD 2013 ZK 005 614, *L'Organisation de Coordination pour la Lutte contre les Endémies en Afrique Centrale*, Plaquette réalisé et éditée par le Secrétariat Général de l'OCEAC à l'occasion de la première Conférence Technique, OCCGE-OCEAC (Paris 2-6 mai 1972), Imprimerie Coulouma : Yaoundé, 8.

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<sup>83</sup> Guillaume Lachenal, "Célébrer le passé, construire le futur: l'indépendance et le microcosme médical au Cameroun," in *Les Indépendances en Afrique: l'événement et ses mémoires: 1957/1960-2010*, ed. Odile Goerg et al. (Rennes: Presses Universitaires de Rennes, 2013), 353-376.

<sup>84</sup> « Cinquantenaire de la Mort de Jamot » *Le Bulletin de Liaison et de Documentation* 85 (1988) : 1-81.



Jamot's methods moreover left an indelible impact on the entire French colonial medical administration in Africa. Following closely on the formation of the sleeping sickness service in Cameroon, Governor General of French Equatorial Africa Raphael Antonetti also established a separate sleeping sickness service for the federation, the *Service de prophylaxie de la trypanosomiase*.<sup>85</sup> The government of French West Africa adopted the same model in 1939.<sup>86</sup> The original mobile health service created a professional culture unto its own and pride, among French colonial doctors and many Africans who worked and trained in this framework, in what they considered to be a distinctly French model of tropical medicine. Jamot's model for mobile health teams thus re-made colonial medical intervention in the French colonies of Africa. Jamot's model also influenced the formation of mobile medical teams in other colonies in Africa. British territories in Africa and the Belgian Congo developed mobile services to address sleeping sickness, services that, like the French mobile teams, would evolve in the postwar period.<sup>87</sup>

## Postwar Reform

After World War II, French colonial officials called for the expansion of the mobile health teams as part of the social and economic reforms of the African colonies laid out in the Brazzaville Conference in 1944. Dr. Marcel Vaucel put forward recommendations to turn the service, focused exclusively on sleeping sickness to this date, to a service addressing endemic

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<sup>85</sup> Headrick, 367.

<sup>86</sup> The service was called the *Service général autonome de prophylaxie et de traitement de la maladie du sommeil* (SGAMS) in French West Africa. Jean-Paul Bado, *Médecine Coloniale et grandes endémies en Afrique* (Paris : Éditions Karthala, 1996), 328-329.

<sup>87</sup> J.L. McLetchie, "Medical Field Units in Nigeria," *Transactions of the Royal Society of Tropical Medicine and Hygiene*, Vol. 48, no. 2 (1954), 156.

and epidemic diseases, such as leprosy, tuberculosis and malaria.<sup>88</sup> The legislation creating the service moreover mandated it to address these diseases by focusing on screening and preventive measures at the level of the ‘collectivity,’ as opposed to a focus on individual medicine.<sup>89</sup> The legislation created a mobile health service for each of the federations of French West Africa and French Equatorial Africa. Cameroon would have its own administratively distinct mobile health service, reflecting its special status as a United Nations Trusteeship.

The new service in Cameroon, now called the *Service d’Hygiène Mobile et de prophylaxie* (SHMP), began functioning as of January 1, 1945, although colonial officials would not finalize its legal attributes until 1947.<sup>90</sup> French military doctor, Médecin-Lieutenant-Colonel Raymond Beaudiment, became the first head of the SHMP in Cameroon. Beaudiment’s medical training followed the standard path through Bordeaux and Marseille of doctors in the *Troupes Coloniales*, and his first colonial posting was to Cameroon in 1929. He completed a training course on site at the center in Ayou and then joined Jamot’s sleeping sickness service.<sup>91</sup> The broader professional ethos of the *Troupes Coloniales* and the specific medical culture forged by Jamot in Cameroon were thus formative to Beaudiment’s early career. Through the new postwar legislation and under Beaudiment’s direction, the newly expanded mission of the SHMP in Cameroon would take shape.

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<sup>88</sup> Jean-Henri Ricossé and Jean-Alain Husser, « Bilan et avenir de la lutte contre les grandes endémies en Afrique occidentale francophone, » *Cahiers d’études africaines* 22 no. 85-86 (1982) : 146.

<sup>89</sup> National Archives of Cameroon, Yaoundé (NAC), 3AC 1103, *Organisation du SHMP et fonctionnement*. « Décret relatif à la création d’un service général d’hygiène mobile et de prophylaxie en Afrique Occidentale Française, en Afrique Equatoriale Française et au Cameroun. »

<sup>90</sup> NAC, 3AC 1103, *Organisation du SHMP et fonctionnement*.

<sup>91</sup> Bado (2011), 281.

The broader turn by France towards colonial development initiatives meanwhile opened up new avenues of funding and equipment for the SHMP. France's postwar fund for colonial development, *Fonds d'investissement économique et social* (FIDES) opened up new possibilities for the SHMP, as more vehicles became available and new roads were built.<sup>92</sup> The vision for modernization embodied in FIDES initiatives thereby bolstered the possibilities of the SHMP for pursuing the goal of medical mobility, thus for more quickly and efficaciously reaching rural populations.

In 1945, the Public Health Service in Cameroon recruited roughly 200 new medical auxiliaries to meet the needs of the SHMP. These recruits underwent three months of training between the *Centre d'Instruction d'Ayos*, in hospitals, and in mobile teams themselves before being assigned to full work on a mobile team.<sup>93</sup> The SHMP corps of doctors necessarily grew at this time as well, but the involvement of the *Corps de Santé Colonial* in French Indochina at this time put the doctors in short supply for the rest of the French empire. The SHMP thus began to employ contractual doctors from outside the corps, the majority of them foreigners.<sup>94</sup> Moreover, as the older French heads of the mobile teams of the *Mission Jamot* began to reach retirement age, these contractual doctors in many instances took over the leadership of the new mobile teams put into place. Thus while SHMP continued to espouse its roots in the French military culture and had Beaudiment as its leader, the on the ground staff of the teams included

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<sup>92</sup> Lachenal (2014), 63.

<sup>93</sup> SHD 2013 ZK 005 113, « Réponses au questionnaire émanant de la Mission d'Inspection de la France d'Outre-Mer, » Yaoundé, le 21 janvier 1954, Le Médecin-Colonel Beaudiment, Chef du Service d'Hygiène Mobile et de Prophylaxie.

<sup>94</sup> SHD 2013 ZK 005 113, « Réponses au questionnaire émanant de la Mission d'Inspection de la France d'Outre-Mer, » Yaoundé, le 21 janvier 1954, Le Médecin-Colonel Beaudiment, Chef du Service d'Hygiène Mobile et de Prophylaxie.

a mix of personnel of other European nationalities as well as the majority of Cameroonian workers.



SHMP at work. *Rapport Annuel du Gouvernement Français à L'Assemblée Générale des Nations Unies sur l'Administration du Cameroun Placé sous la Tutelle de la France, Année 1954*

Leadership of the teams by “African doctors” (*médecin-africain*) a status designating training at the Dakar Medical School beyond that of a nurse but below that of a French physician, did occur in a limited fashion in the late 1940s.<sup>95</sup> In 1949, two *médecin africain* worked in leading the teams.<sup>96</sup> French officials, however, disparaged the work of the African

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<sup>95</sup> The *Ecole de médecine de l'Afrique Occidentale Française* in Dakar was established in 1918 and only accepted students from the federation of French West Africa to train as “médecins auxiliaires.” Legislation originating in the Brazzaville Conference in 1944 changed the mandate of the institution to also accept students from French Equatorial Africa and Cameroon. The name of the school changed to the *Ecole Africaine de Médecine et de Pharmacie* and offered a course of study leading to the title of “médecins africains,” thus standardizing this position across the French empire in Africa. With this change, training of “aides de santé” in Ayos, Cameroon ceased. Graduates and active students at Ayos became eligible for entry to the Dakar school. Sonne (1983), 190-235.

<sup>96</sup> The report does not specify whether these doctors were of Cameroonian origin. SHD 2013 ZK 005 110, *Rapport Annuel, Service de la Santé Publique, Cameroun Français, Année 1949, par le Médecin-Commandant Creste, Directeur du Service de la Santé Publique*, 86. In 1949, the SHMP African personnel included 2 Médecins Africains, 139 nurses, 1 sanitary assistant, 1 ‘agent d’hygiène’ and 41 ‘agents divers,’ for a total of 184 personnel. 27 European personnel worked for the SHMP in this year. By contrast, there were 889 African personnel working in hospitals and other health posts in the same year. This included 56 médecins africains.

doctors in this realm, and the two were relieved of their duties in 1950.<sup>97</sup> Therefore, even as the medical corps within Cameroon grew to include 61 *médecin africain* by 1950, these more highly-trained individuals by and large did not work in the SHMP. Those Cameroonians in the 1950s who eventually went on to further training in France to obtain the doctorate in medicine, the full training on par with that of a French physician, for the most part did not return to the country until the early 1960s.<sup>98</sup> The mobile service thus maintained a particularly stark hierarchy between European doctors or sanitary agents and Cameroonian nurses and auxiliaries. This jealous guarding of leadership was but one of the ways that French military doctors of the SHMP made a claim on a unique form of expertise about the work of mobile medicine and vaccination within Cameroon.

As the personnel and the stated mission of the SHMP grew, the service faced numerous challenges in realizing this mission. Hampered by delays in receiving equipment, insufficiency of vehicles and personnel, and resistance of the Cameroonian population, the SHMP postwar project was often far from realized.<sup>99</sup> With only six teams operating by 1948, the SHMP teams visited a limited number of areas within Cameroon in that year, recording seeing a total of 322,200 people, as it primarily continued work focused on sleeping sickness.<sup>100</sup> But for Beaudiment, one of the most regrettable factors hampering the mobile teams was the fact that

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<sup>97</sup> SHD 2013 ZK 005 110, *Rapport Annuel, Service de la Santé Publique, Cameroun Français, Année 1950, par le Médecin-Colonel Vaisseau, Directeur du Service de la Santé Publique*.

<sup>98</sup> Elie Claude Ndjitoyap Ndam, *De l'Aide de Santé...au Médecin : Réflexions sur la genèse, l'évolution et les perspectives de la formation médicale au Cameroun* (Yaoundé : Cameroon University Press, 2002), 57.

<sup>99</sup> SHD 2013 ZK 005 110, *Rapport Annuel, Service de la Santé Publique, Cameroun Français, Année 1948, par le Médecin-Colonel Vaisseau, Directeur du Service de la Santé Publique*, 96.

<sup>100</sup> SHD 2013 ZK 005 110, *Rapport Annuel, Service de la Santé Publique, Cameroun Français, Année 1948, par le Médecin-Colonel Vaisseau, Directeur du Service de la Santé Publique*, 101. In 1948, the SHMP reported visiting the regions : Bamileke, Haut-Nyong, Kribi, Lom et Kadei, Nord Cameroun, N'Tem, Nyong et Sanaga, Wouri.

Cameroonians were increasingly not cooperating when called to assemble for the team visits. The SHMP began to quantify the percentage of population that attended its visits as a major measure of its work and to map where absenteeism happened most.<sup>101</sup> As nationalist movements took root across southern Cameroon in the 1950s, this map of medical “indiscipline” became, moreover, imbued with ideas about ethnic groups and their ties to these political movements.<sup>102</sup> These questions about absenteeism and cooperation would raise new issues as well in the context of the WHO malaria program.

Through the 1940s, the Public Health Service in Cameroon pursued only very limited anti-malaria work. In 1949, insecticide spraying was undertaken for the first time in the capital of Yaoundé, but these first efforts primarily lowered malaria rates among the European population.<sup>103</sup> These anti-malaria efforts did not extend to the vast majority of rural populations through the 1940s, a limitation that French officials attributed to budget constraints. The postwar creation of new international health organizations, however, would create new sources of funding for colonial medical administration. A Cameroonian doctor, Etienne Bilounga, wrote his medical thesis on the 1950s malaria program in Cameroon and wrote that, while these colonial budget constraints around malaria work “condemned” the villager to this “sad state” that “at last manna fell from the sky with the creation of the World Health Organization.”<sup>104</sup>

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<sup>101</sup> Lachenal (2014), 67.

<sup>102</sup> Lachenal (2014), 67. Lachenal paraphrases Achille Mbembe in referring to record keeping by the SHMP as a mapping of the “terroirs de l’indiscipline,” focused on Bamileké areas.

<sup>103</sup> H.G.S. Morin, « Sur une campagne antipalustre au Cameroun (1953-1954), *Rivista di Malariologia* 34 (1955) : 38.

<sup>104</sup> Etienne Bilounga, *Contribution à l’Étude du Paludisme Résiduel en Zone Pilote du Sud Cameroun* (Thèse, Faculté de Médecine de Paris, 1964), 3.

## International Organizations and Health in Postwar Cameroon

The postwar re-ordering of international politics, embodied in the creation of the United Nations, would carry significant changes for Cameroon's broader political future, as well as for its colonial health administration. The new United Nations established the Trusteeship system, meant to have a stronger power of supervision over colonial powers than that which had existed under the League of Nations, and ultimately to move colonies towards self-government. France initially tried to block the placement of any of its territories under the Trusteeship system and only agreed in the face of significant international pressure.<sup>105</sup> The British Cameroons and French Cameroon thus both became United Nations Trusteeships. Through this arrangement, the United Nations required France and Britain to produce annual reports on their administrations of the territories, as well as to host visits by a UN visiting mission to observe this administration. These requirements by the UN revealed the "implied critique of imperialism" that was central the UN trusteeship system.<sup>106</sup>

In light of this critique, France sought to defend its rule by advancing a positive portrait of colonial administration in Cameroon. France's investment in the medical services of Cameroon became one of the ways in which it sought to present its administration of Cameroon as a progressive, modernizing force.<sup>107</sup> Médecin-Colonel Vaisseau, Director of Public Health in

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<sup>105</sup> David E. Gardinier, *Cameroon: United Nations Challenge to French Policy* (London; New York: Oxford University Press, 1963), 3-9. An anti-colonist block in the United Nations sought to have all colonies placed under trusteeship, while European colonial powers sought to block the creation of the trusteeship system. With the trusteeship system in place, France then sought to avoid putting Cameroon under its supervision. The final trusteeship agreement reached with France and the United Nations left a great deal of ambiguity as to the final goals of the trusteeship; France's agreement stated that it would administer Cameroon 'as an integral part of French territory.'

<sup>106</sup> Gordon W. Morrell, "A Higher Stage of Imperialism? The Big Three, the UN Trusteeship Council, and the Early Cold War," in *Imperialism on Trial*, ed. R.M. Douglas, Michael D. Callahan, and Elizabeth Bishop (Lanham, MD: Lexington Books, 2006), 130.

<sup>107</sup> Lachenal (2014), 78.

Cameroon, for example, wrote to colonial doctors in 1949 to prepare for an upcoming visit by the UN Trusteeship council by asking them to “put in as good a state as possible existing premises: hospitals, dispensaries, and leprosarium” and to “accelerate the work of major repairs and maintenance underway.”<sup>108</sup> Colonial officials thus sought to present the best possible portrait of an advanced and growing medical system to the UN council.

The Trusteeship arrangement also made the role of the United Nations’ specialized technical agency, the World Health Organization, hold special import in Cameroon. French officials used WHO support and programs to foster an image of Cameroon as an important site of *international* health research and training, simultaneously asserting that ongoing French governance would best facilitate this health internationalism. The launch of the malaria eradication program in Cameroon would create new circumstances by which the French colonial government could at once use resources offered by the WHO and then report back positively to the UN on its engagement. Thus while French colonial officials had objected to the Trusteeship arrangement, health officials on the ground not only benefited from new sources of technical and material support but also helped use these resources as new forms of political capital before the UN. In the case of French West Africa, the French colonial government similarly sought to present itself as a modernizing force, in part through health and family welfare programs, before the UN Special Committee on Non Self-Governing Territories.<sup>109</sup> The greater degree of international oversight afforded to the Trusteeship Council in Cameroon,

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<sup>108</sup> NAC 2AC 136, Circulaire no. 580/C à M. les Médecins-chefs des Organismes centraux et des Formations sanitaires Régionales, Yaoundé, le 31 Mai 1949, Le Médecin-Colonel Vaisseau, Directeur de la Santé Publique.

<sup>109</sup> Pearson-Patel (2013).



however, created uniquely high political stakes for the presentation of colonial rule before the UN relative to other territories.

The founding of the World Health Organization, as one of the specialized technical agencies of the United Nations, marked a significant new framework for international health coordination and specifically for public health in Africa. Founded in 1948, the World Health Organization mobilized the postwar vision of international development in the field of public health. The organization, like all of the new UN technical agencies, sought to work in Africa, Asia, and Latin America, through the framework of international experts pursuing supposedly apolitical projects aimed at overall social and economic well-being. Against the backdrop of the Cold War and American dominance in the agency, however, the WHO diverged in significant ways from this ideal of a ‘depoliticized’ health organization.<sup>110</sup> Notably, the WHO also became quickly enmeshed in the politics of colonialism. French colonial medical officials generally viewed the plans of the World Health Organization to pursue health programs in Africa with a great deal of suspicion, worried that this work might ultimately undermine French power in Africa. At the same time, however, they saw in the WHO a source of new funding and resources.<sup>111</sup> The WHO thus created a new international context for the colonial administration of public health, and the organization’s policies and programs would likewise both create new opportunities and narrow certain possibilities for health work.

Whereas the WHO at first adopted a broad view of health, rooted in earlier conceptions of social medicine, it turned by the 1950s to a more narrow vision of improving health through

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<sup>110</sup> Packard (2016), 1997.

<sup>111</sup> Jessica Pearson-Patel, *From the Civilizing Mission to International Development: France, the United Nations, and the Politics of Family Health in Postwar Africa, 1940-1960* (Dissertation, New York University, 2013).

technical solutions, rather than through broader social reform.<sup>112</sup> The WHO's official decision to pursue a global malaria eradication program in 1955 signaled this change. Historians have well explored the impetuses and ultimate failure of this campaign at a global level.<sup>113</sup> Spurred by the hope that technical solutions would drive development, international health officials sought to spread a universal method of combatting malaria with the insecticide, DDT. This eradication campaign took on many dimensions in its various settings across the globe, but despite some initial successes in interrupting malaria transmission, international health officials failed to account for the inordinate ecological and social complexity of malaria transmission.

International health officials moreover cast sub-Saharan Africa as a particular challenge for malaria eradication, and despite the name of the 'global' eradication program, the WHO did not include Africa on equal footing with other world regions in the eradication program. Instead of supporting full eradication programs in Africa, as was being done elsewhere across the globe, the WHO supported a series of pilot programs in Africa to test methods for malaria eradication that, once proven successful, could be scaled-up.<sup>114</sup> A contentious debate among WHO and colonial health officials in the early 1950s about how insecticide-spraying campaigns might affect adult-acquired immunities to malaria among Africans drove the early hesitation to pursue full eradication programs.<sup>115</sup> Although this concern subsided to a degree in the early

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<sup>112</sup> Packard (2016), 105-131.

<sup>113</sup> Stepan, 140-183. Marcos Cueto, "A Return to the Magic Bullet? Malaria and Global Health in the Twentieth Century," in *When People Come First: Critical Studies in Global Health*, ed. João Biehl and Adriana Petryna, (Princeton, NJ: Princeton University Press, 2013), 30-53. Randall Packard, "No other logical choice': global malaria eradication and the politics of international health in the post-war era," *Parrasitologia* 40 (1988): 217-218.

<sup>114</sup> James Webb, *The Long Struggle against Malaria in Tropical Africa* (New York: Cambridge University Press, 2014), 79.

<sup>115</sup> Webb 2014, 74-78. Nancy Leys Stepan, *Eradication: Ridding the World of Diseases Forever?* (Ithaca, NY: Cornell University Press, 2011), 160-163.

1950s, many concerns about the possibility of interrupting malaria transmission across Africa remained. WHO officials designed the pilot projects as a way forward, to explore how malaria eradication could be pursued in cost-effective ways in different ecological contexts.<sup>116</sup>

In addition to these pilot projects, the WHO and UNICEF began to support select malaria control programs run by colonial health services in the early 1950s. The 1952 visit of WHO malariologist Dr. Pampana to Cameroon, described in the beginning of the chapter, occurred as part of a joint visit with French, WHO and UNICEF representatives to French West Africa and Cameroon to draft plans for these malaria programs. The WHO ultimately provided funding for malaria control in six zones across French West Africa, Togo and in Cameroon.<sup>117</sup> In Cameroon, agreements between the French government and the WHO and UNICEF created plans for insecticide-spraying programs in two large zones in southern and northern Cameroon. The SHMP would run these programs on the ground with material and technical support from the international organizations.

Cameroon would additionally host a special WHO-supported ‘international pilot zone’, headquartered in Yaoundé; this site would be the only one of the malaria agreements with the French government to include WHO personnel on the ground in Africa. According to the

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<sup>116</sup> Webb 2014, 79. The pilot projects also corresponded in many cases to sites of colonial agricultural modernization schemes. Mathieu Fintz has argued that through the creation of the pilot zones in Africa, health officials created a new kind of frontier between the ‘civilized’ and the ‘savage.’ They saw attempting malaria eradication in these zones as a worthwhile pursuit, whereas beyond the zones, a *laissez-faire* approach to malaria continued. He moreover argues that this was a reformulation of former ideas of sanitary segregation, between Europeans and Africans, which cast understandings of malaria in terms of race. Mathieu Fintz, « Les Métamorphoses du Gouvernement du Parasitisme en Afrique : Insecticides, frontières et civilisation dans la lutte antipaludique (1930-1962), » *Politix* 74 (2006) : 149-171.

<sup>117</sup> World Health Organization, *Regional Committee for Africa, Fifth Session, Annual Report of the Regional Director*, July 1 1954-30 July 1955, WHO doc AFR/RC5/3, 30. The six zones were in Senegal, Haute Volta, Togo, Dahomey, North Cameroon and South Cameroon. France, the WHO and UNICEF signed a tripartite agreement for the whole malaria control program in May 1952.

agreement, a malaria specialist and an assistant would take up postings in Yaoundé. The WHO would also provide “special laboratory supplies, and equipment and fellowships.” UNICEF would provide insecticide and spraying equipment, along with means of transportation for the campaign. France agreed to provide “all local and medical auxiliary staff, buildings for offices and laboratories, etc.” The pilot zone would focus on an area surrounding Yaoundé with a population of approximately 46,000 people. The proposed purpose of the pilot zone near Yaoundé was ‘to find out whether residual house-spraying is an effective and economic means of controlling or stopping transmission in this forest area, hampered by poor communications.’<sup>118</sup> The pilot zone would focus on field trials of different insecticides to test their applicability for other areas of equatorial Africa.<sup>119</sup> As a site of WHO pilot projects and the Yaoundé pilot zone, Cameroon thus became a specialized site within Africa, meant to test the feasibility of larger-scale malaria eradication program. WHO officials pointed to the importance of Cameroon as the “land of African experience,” chosen by its experts for research due to four principle physical geographies found in sub-Saharan Africa existing within the territory.<sup>120</sup>

The creation of the ‘international pilot zone’ moreover added a new dimension to Cameroon’s status as both a colony and an international Trusteeship. Through this arrangement, the French colonial medical service was able to operate as both a colonial administration and as

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<sup>118</sup> World Health Organization, *Regional Committee for Africa, Fifth Session, Annual Report of the Regional Director*, July 1 1954-30 July 1955, WHO doc AFR/RC5/3, 30.

<sup>119</sup> The pilot zone would focus on three main insecticide: DDT, HHC and Dieldrin.

<sup>120</sup> Morin, 46. “Le Cameroun, terre d’expérience africaine a été choisi par les experts de l’O.M.S. parce qu’il offre sur un territoire restreint quatre types physiographiques principaux du continent noir : la côte basse et marécageuse, la grande steppe intérieure qui va du Sénégal au Nil, la zone forestière de moyenne et basse altitude et enfin les hautes terres à mille mètres au-dessus de la mer. »

a participant in the new postwar internationalization of public health. The existence of the pilot zone moreover brought WHO personnel to direct postings in Cameroon, prompting the creation of new on the ground arrangements of international and colonial expertise.

### **International and Colonial Expertise in Yaoundé**

The creation of the pilot zone in Yaoundé created arrangements between international health programs and colonial medical administration unlike others occurring in the French empire in Africa, in that two WHO technical personnel would take up postings there to oversee the international pilot zone. The Yaoundé pilot zone created a new liminal space of international and colonial health. In this new space, WHO personnel both relied on and at times sought to distinguish their approach and their methods from the SHMP. Over time, however, they came to rely closely on the types of knowledge and the systems of rural health intervention generated by the SHMP. A WHO malaria consultant (of whom there were 3 over the course of the 1950s) maintained an active hand in malaria research in Yaoundé in the 1950s, but the SHMP's dominance over the operations of the overall program also increased during this time.

The distinction between the 'international' status of the first WHO malaria consultant in the pilot zone and 'French colonial' personnel, was moreover, quite ambiguous, given common career backgrounds in the French military medical corps. The first WHO head of the Cameroon pilot zone—malariologist Dr. Henry Morin—arrived in Yaoundé in April 1953.<sup>121</sup> This lead 'international' expert was French, and the primary institutions of the French military medical corps forged his education and career. Morin trained at *l'Ecole de médecine navale de*

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<sup>121</sup> World Health Organization, *Regional Committee for Africa, Fifth Session, Annual Report of the Regional Director*, July 1 1954-30 July 1955, WHO doc AFR/RC5/3, 30.

*Bordeaux* and the *l'Ecole d'application du service de Santé des Armées du Pharo* in Marseille, where he later became a clinical professor. Morin thus came from the same professional milieu as the French doctors serving in the SHMP. After leaving the colonial medical corps in 1922, Morin worked in Pasteur Institutes in French Indochina. His full biography is a striking example of how medical officials moved between colonial and international health spaces in the early 20<sup>th</sup> century; in addition to his career within French institutions, he worked on the Commission of Experts on Malaria for the League of Nations and led international studies in the late 1940s on a grant from the Rockefeller Foundation.<sup>122</sup> His work in Yaoundé for the international pilot zone was the last posting before he retired in 1955. The WHO's second staff person, RJ Smith, was British. Another French malariologist, trained in Paris, Mr. E. Sejour, arrived to join the team in October 1953.<sup>123</sup>

The pilot zone research staff also incorporated existing medical and scientific personnel in Cameroon. An entomologist, J.P. Adam, simultaneously held postings with the pilot zone and in the laboratory of the French O.R.S.T.O.M (*l'Office de la Recherche et Technique d'Outre-Mer*) in Cameroon. The team of the pilot project grew in August 1953 to include personnel directly from the SHMP. A European sanitary agent from the SHMP who had been working in Northern Cameroon joined to work with Smith, the WHO assistant. A secretary from the mobile service trained in doing village surveys joined to assist a Cameroonian nurse, André Ateba, working on the establishment of epidemiological statistics. Finally, Dominique Effa, a nurse recently graduated from *L'Ecole d'Ayos*, the school rooted in Jamot's creation of

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<sup>122</sup> Services des Archives de l'Institut Pasteur, *Repères chronologiques, Henry Morin (1889-1969)*, <http://webext.pasteur.fr/archives/f-bio.html> Accessed August 18, 2016.

<sup>123</sup> SHD 2013 ZK 005 233, *Organisation Mondiale de la Santé Région Afrique, Zone Pilote au Cameroun, Rapport Mensuel no. 4 (Septembre-Octobre 1953)*.

the mobile health teams, joined the pilot zone laboratory.<sup>124</sup> The SHMP established the laboratory for the pilot zone in 1953 in an old administrative building in Yaoundé.<sup>125</sup> Thus, while the WHO personnel led the research of the pilot zone, their work quickly became integrated with infrastructure and personnel of both the SHMP and the broader colonial medical and scientific landscape in Yaoundé.

In the early months of the pilot zone in 1953, the WHO staff set out with the objective to conduct ‘pre-operational’ surveys on malaria in the area before the launch of a house-spraying campaign. They sought to identify and map out the exact varieties of mosquitos that were acting as vectors in malaria transmission, with the premise that this information would greatly aid in the efforts to interrupt malaria transmission. Their research would also seek to understand how malaria transmission functioned within different ecological settings and within the context of different practices of people—including where and how they slept, if they engaged in agricultural cultivation, etc.<sup>126</sup> Monthly reports from the WHO staff during these early months illuminate their efforts to acclimate themselves to a new terrain in Cameroon. They released their first monthly report in July 1953, sent to the High Commissioner of Cameroon, to the WHO and to UNICEF. Morin and Smith sought to sketch out this understanding—demographic, geographic, epidemiological and entomological—of their new work site. Morin, for example wrote that ‘racial and tribal’ differences between Cameroonians

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<sup>124</sup> SHD 2013 ZK 005 233, *Organisation Mondiale de la Sante Région Afrique, Zone Pilote au Cameroun* (A.F.1.), *Rapport Mensuel no. 2* (Août 1953). The *agent sanitaire* of the SHMP that joined the team was Mr. Muller (no first name given).

<sup>125</sup> SHD 2013 ZK 005 113 « Réponses au questionnaire émanant de la Mission d’Inspection de la France d’Outre-Mer, Chapitre 1-Attributions du Service », le 21 janvier 1954, Le Médecin-Colonel Beaudiment, Chef du Service d’Hygiène Mobile et de Prophylaxie.

<sup>126</sup> This research reflected the consensus reached among health officials at the 1950 Malaria Conference in Equatorial Africa, held in Kampala about the need for more local entomological investigation on malaria. Webb, 82.

were not easily discernible to the newcomer, and he wondered if his investigations would ultimately yield fine grain differences of customs between the Ewondo and Eton.<sup>127</sup> Morin and Smith painted themselves as scientific experts but also as novices in the broader circumstances of their new posting.

During this time, the WHO staff thus began to rely on the SHMP for creating an initial knowledge base about malaria and about the general terrain of Cameroon. As part of his ‘pre-operational’ information gathering, for example, Dr. Morin turned to a report on malaria in northern Cameroon that a French doctor had conducted under the direction of Beaudiment, the head of the SHMP.<sup>128</sup> R.J. Smith’s preliminary work in the pilot zone focused on preparing topographical maps, and he began this work by using previous sketches from the SHMP, along with other government surveys.<sup>129</sup> In August, Smith met with Beaudiment and used his records on house-spraying operations within Yaoundé to try to calculate how many houses per day teams could spray in the pilot program.<sup>130</sup>

At the same time, Morin and Smith expressed that they needed information beyond what the SHMP could provide in this pre-operational phase and they set out to pursue this work independently. They were particularly concerned at this stage of planning with how they would organize travel and reach certain villages to conduct their research. Smith sought to add to the

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<sup>127</sup> SHD 2013 ZK 005 233, *Organisation Mondiale de la Sante Région Afrique, Zone Pilote au Cameroun, Rapport Mensuel no. 1 (Juillet 1953)*.

<sup>128</sup> SHD 2013 ZK 005 233, *Organisation Mondiale de la Sante Région Afrique, Zone Pilote au Cameroun, Rapport Mensuel no. 1 (Juillet 1953)*.

<sup>129</sup> SHD 2013 ZK 005 233, *Organisation Mondiale de la Sante Région Afrique, Zone Pilote au Cameroun, Rapport Mensuel no. 1 (Juillet 1953)*.

<sup>130</sup> SHD 2013 ZK 005 233, *Organisation Mondiale de la Sante Région Afrique, Zone Pilote au Cameroun, Rapport Mensuel no. 2 (Août 1953)*.



information he gained through Beaudiment and the SHMP through his own local travel, reporting:

During the month an opportunity has been taken to explore some of the tracks leading to villages off the main routes. Some of the tracks are only 'Jeepable' and then with extreme difficulty, further obstacles being presented. (sic) By bridges that are either broken, or too weak to carry the weight of a vehicle, for those reasons it is envisaged that when the need comes to transport DDT, squads, etc to those areas we shall be presented with some difficulty.<sup>131</sup>

The logistics of travel and rural access thus became an immediate concern.

For Morin, however, the question of how to organize travel touched a nerve over what he saw as the difference between the SHMP and the work he was trying to accomplish. Morin grew impatient with some of the local adaptations of his planned operation, represented in part through his work with Beaudiment on securing means of transportation. Beaudiment, for example gave the team use of a 'personnel carrier' vehicle, to facilitate more frequent prospecting trips and allow them to bring enough personnel to do both entomological and epidemiological surveys. Morin, however, saw a need for bicycles to conduct surveys in locations in closer distance to the center, and he saw it as a waste to use a vehicle for every such trip. Noting that bicycles "which had been of such great service in other initiatives, had bad press in Yaoundé," Morin indicated that Beaudiment advised against their use. Morin hoped to change his mind on the matter.<sup>132</sup>

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<sup>131</sup> SHD 2013 ZK 005 233, *Organisation Mondiale de la Sante Région Afrique, Zone Pilote au Cameroun, Rapport Mensuel no. 1 (Juillet 1953)*.

<sup>132</sup> SHD 2013 ZK 005 233, *Organisation Mondiale de la Sante Région Afrique, Zone Pilote au Cameroun, Rapport Mensuel no. 2 (Août 1953)*. The SHMP did eventually furnish the international pilot zone with six bicycles: SHD 2013 ZK 005 233, *Organisation Mondiale de la Sante Région Afrique, Zone Pilote au Cameroun, Rapport Mensuel no. 6 (25 Novembre-25 Décembre 1953)*.

More than a minor matter of opinion to Morin, he saw this question of travel logistics as cutting to the heart of much broader questions about the difference between his task and that of the SHMP:

Incidentally, we are experiencing here one of the major errors of organization committed in the creation of this team. Instead of taking inspiration from acquired experience that showed the necessity of putting at the Team Leader's disposal equipment, of which the standard list was set after long discussions between experts as being likely the best, because it was the most practical, it seemed preferable according to the impressions of several of the organizers to modify the list and the distribution of equipment. So that, except for the materials of the laboratory, often in short supply, the team in Cameroon having not benefited from any special distribution for the pilot zone, finds itself from the point of view of vehicles, insecticides, and spraying apparatuses, completely dependent on the SHMP. But, by definition, the task ahead is new, if not, it would have already been long accomplished. It therefore requires techniques and organization that are by definition different than that which has been previously implemented and of course special equipment. If it were enough in Africa in general and in Cameroon in particular to continue to do that that which had been previously accomplished, it would not have been useful to form malaria survey teams.<sup>133</sup>

In the very infancy of the malaria program, the WHO official thus sought to place his work within the context of a more international framework of entomology and the science of malaria transmission. He insisted upon the differences between his highly detailed and specialized work of mapping malaria vectors as opposed to the kind of mapping that the SHMP had already undertaken in Cameroon. He asserted these claims with reference to his four previous years of experience in three other world regions and in roughly twenty malaria projects. Morin thus asserted himself as an internationally grounded expert on malaria and contrasted this with local—in this case meaning colonial—forms of knowledge on how to execute campaigns.

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<sup>133</sup> SHD 2013 ZK 005 233, *Organisation Mondiale de la Sante Région Afrique, Zone Pilote au Cameroun, Rapport Mensuel no. 2 (Août 1953)*.

Within only a few months, however, Morin began to recognize some of the perspectives of Beaudiment on malaria as more valuable than he imagined. Morin became to appreciate Beaudiment's insight, for example, on having "insisted on the contrast between the situation in the region of Maroua and that of Evoudoula," thus pointing out the differences in malaria prevention in the sahelian north and the equatorial south.<sup>134</sup> Morin noted that initial investigations were confirming some of the observations of Beaudiment; Morin pointed to Beaudiment's long colonial experience and connection to the "services of this admirable institution of 'Hygiène Mobile' which remains the most fine memorial to the glory of Doctor Jamot."<sup>135</sup> Morin thus began to show his admiration for the system that marked his own French training, as well as the position of Beaudiment as a colonial intermediary. Morin noted with satisfaction, moreover, that the vehicles supplied by Beaudiment to the pilot zone team turned out to be "exactly adapted to local needs."<sup>136</sup>

Following these pre-operational surveys, the first round of house spraying with insecticides began in the pilot zone area in February 1954 and continued through May. Teams sprayed 10,000 homes spread over 200 villages during this time.<sup>137</sup> This spraying sought to test the relative effectiveness of three different types of insecticides.<sup>138</sup> The pilot zone staff oversaw the creation of two specialized teams to conduct the insecticide spraying. Each team would

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<sup>134</sup> SHD 2013 ZK 005 233, *Organisation Mondiale de la Sante Région Afrique, Zone Pilote au Cameroun, Rapport Mensuel no. 4 (Septembre-Octobre 1953)*.

<sup>135</sup> SHD 2013 ZK 005 233, *Organisation Mondiale de la Sante Région Afrique, Zone Pilote au Cameroun, Rapport Mensuel no. 4 (Septembre-Octobre 1953)*.

<sup>136</sup> SHD 2013 ZK 005 233 *Organisation Mondiale de la Sante Région Afrique, Zone Pilote au Cameroun, Rapport Mensuel no. 9 (20 Février-20 Mars 1954)*.

<sup>137</sup> World Health Organization Library, Regional Committee for Africa, Sixth Session, Luanda, 24-19 September 1956, *Annual Report of the Regional Director, 1 July 1955-30 June 1956*, AFR/RC6/3, 32.

<sup>138</sup> DDT, HCH and Dieldrin.

consist of one ‘European’ manager, one driver and three groups of workers. Each group in turn included a person in charge of each task of surveying, mixing the insecticide and recording, and four people for spraying. Outside of this ‘European’ head of the team, the rest of the workers would thus be Cameroonian.<sup>139</sup> Mr. Muller, the SHMP sanitary agent who had joined the pilot zone staff, divided the pilot zone region into two parts for the work of the teams, each with further demarcated sub-divisions meant to correspond roughly to a ‘traditional administrative grouping.’<sup>140</sup> The SHMP warehouse in Yaoundé meanwhile kept the teams equipped with necessary supplies such as oil, gas and the insecticides themselves.

The early operations in the Yaoundé pilot zone thus forged new working relationships between the colonial medical service and WHO personnel. While all supported the new goals of research that were meant to eventually advance the pursuit of malaria eradication, this work required an on the ground infrastructure that necessarily involved both French medical personnel and Cameroonian auxiliaries. Because of the WHO’s design of the project, to both create new knowledge about malaria transmission and to pursue house spraying outside of urban areas, the international staff naturally came to rely on the SHMP, itself already working through these same avenues.

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<sup>139</sup> SHD 2013 ZK 005 117, *Organisation Mondiale de la Santé, Zone Pilote, Rapport Mensuel No. 8 (20 Janvier-20 Février 1954)*. The first two team heads were Frenchmen, Ivan Fabry and Bernard Lepape. Drivers Martin Ako and Jean Amougou joined the pilot zone teams shortly after. *Organisation Mondiale de la Santé, Zone Pilote, Rapport Mensuel No. 9 (20 Février-20 Mars 1954)*.

<sup>140</sup> SHD 2013 ZK 005 117, *Organisation Mondiale de la Santé, Zone Pilote, Rapport Mensuel No. 8 (20 Janvier-20 Février 1954)*. Muller divided the pilot zone into two sectors-North and South—each of which was divided into 3 sub-sectors and, in turn, 12 districts-numbered 1 through 24.

## **The SHMP and the Malaria Program.**

While the SHMP officials confidently played the role of ‘local’ intermediaries for WHO officials in the early days of the pilot zone, they also oversaw the broader malaria programs in the north and south of Cameroon.<sup>141</sup> For the SHMP, the spraying of homes with insecticide created new practices of rural health intervention and new discourses about what this work meant. At the operational level, mobile teams required access to homes in order to do spraying and they generally asked that people remove belongings from the home in order to spray the walls with insecticide. This type of intervention, focusing on the home rather than the body, thus created new kinds of language about what cooperation entailed. Previously, people fleeing or not appearing at assembly lines for vaccination or medical screening had represented resistance to the mobile teams. Now the ‘closed door,’ or the absence from the home, became a sign of resistance or ‘passivity’ in the face of the power of DDT. In different ways, both colonial and international health officials criticized Cameroonians posing these obstacles to access for spraying. The advent of the spraying campaigns thus expanded the repertoire of the interventions of the SHMP from the African body to the geographic space of the home and the village.

The international context of the campaign, and the attention to the idea of a global eradication of malaria, added credence to this expanding intervention. The launch of the spraying campaigns connected these SHMP tours to an internationalized framework for public health intervention. In this framework, the mobile teams would physically deliver the

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<sup>141</sup> The southern campaign targeted an estimated population of 800,000 people and began with yearly spraying of the insecticide, Dieldrin. This campaign focused on nine administrative regions: Sanaga Maritime, Kribi, Mbam, Nyong et Sanaga, Ntem, Dja et Lobo, Lom et Kadéï, Boumba-Ngoko. The northern campaign targeted a population of 390,000 people in the region of Diamaré. R. Chastang, “Quatre années de lutte antipaludique au Cameroun meridional,” *Médecine Tropicale : Revue du Corps de Santé Colonial* 19 (1959) : 51-86.

modernizing postwar technologies of health to rural areas. A French colonial publication in postwar Cameroon completely devoted to the question of health, *Hygiène et Alimentation au Cameroun*, highlighted the new accords signed with international organizations for the malaria program. It reported in 1953 that “A very important new effort will be undertaken with the support of UNICEF and the WHO. The government has decided to bring the benefits of DDT to the villages of the bush (*villages de brousse*).”<sup>142</sup> The French term ‘brousse’ designated a starkly conceived colonial geography, with the ‘brousse’ being that which was beyond the easy reach of roads, themselves markers of a modernized mobility. French colonial officials thus cast their role as delivering DDT to the ‘brousse’ through their own infrastructure but with the markings of support of the new postwar international health organizations.

The launch of the insecticide program in the north exemplified these new dynamics. Teams began spraying in the north in March 1953, leaving from Maroua and traveling to designated sectors in the surrounding area. Seven teams led the spraying campaign in the north. Each team included a ‘european’ team manager, with thirteen Cameroonian workers including one driver, two people to mix the insecticide and ten sprayers. Each team also had its own *Renault 2t5* truck.<sup>143</sup> Beaudiment followed the work of the spraying teams in the first few weeks to see how the program unfolded on the ground. He expected a degree of difficulty based on his characterizations of the people in the area, calling on tropes about the Fulbé being “rather averse” due either to their Islamic religion or customs and about the “Kirdi,” a general term for non-Islamized ethnic groups in the north, as “primitive”.<sup>144</sup> Beaudiment observed all

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<sup>142</sup> Bibliothèque Nationale de France (BNF), “Contre le Paludisme: Les Insecticides de Contacts,” *Hygiène et alimentation* No.17-1. Janvier 1953.

<sup>143</sup> BNF, “La Guerre aux Moustiques,” *Hygiène et alimentation* No. 19-1. Juillet 1953.

<sup>144</sup> BNF, “La Guerre aux Moustiques,” *Hygiène et alimentation* No. 19-1. Juillet 1953.

the same that the novelty of the house-spraying presented difficulties for both the workers and inhabitants. One major structural issue arose with the necessity of water to mix the DDT for spraying. In the district of Bougaye, for example, the SHMP doctor noted that villages lacked an easy water source; during the dry season people were obligated to travel 20 kilometers by foot to reach a water source. The teams thus had to adjust their plans for villages to provide water for the spraying operation.<sup>145</sup> Thus while the SHMP director accepted this adjustment in some locations, in others he lamented a “disheartening inertia” of the population. He thus took it upon himself to strengthen the SHMP system of exerting pressure through traditional authorities. The doctor met himself with Fulbe *lamibé* as well as reviewed the messages about the project that the spraying teams should also share with authorities during village visits.

Beaudiment subsequently noted a marked change in the reception of house spraying and attributed it both the messaging and to the power of DDT. While he doubted people’s understanding of the intended effect of DDT in stopping malaria transmission, inhabitants of sprayed homes also noted with satisfaction the impact of killing vermin and other pests. With this concrete outcome of the work, people took “a more active role in the work of the teams, to much more willingly provide the water requested of them...and to direct the workers so that no hut was forgotten.”<sup>146</sup> The doctor noted that this aid “notably accelerated” the work of the teams.

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<sup>145</sup> BNF, “La Guerre aux Moustiques,” *Hygiène et alimentation* No. 19-1. Juillet 1953. Colonial officials’ ideal for the malaria program was that villages would provide water for mixing of insecticide. In 1954, for example, the Director of Public Health for Cameroon had the information service for the Cameroon High Commissioner photograph women in the village of Simbok providing the water for the teams ‘in order to spread and popularize these practices.” SHD 2013 ZK 005 233 *Organisation Mondiale de la Sante Région Afrique, Zone Pilote au Cameroun, Rapport Mensuel no. 9 (20 Février-20 Mars 1954).*

<sup>146</sup> BNF, “La Guerre aux Moustiques,” *Hygiène et alimentation* No. 19-1. Juillet 1953.

The SHMP doctor framed his role in overseeing the teams in fostering what he called these “factors of acceleration.” Thus in addition to the involvement of the population, he focused on how the teams needed to adapt to the different geographic and physical conditions of different locales. Whereas in some areas, villages might be easily accessible and close together, others might be dispersed and require climbing mountains.

Near Kalfous, by contrast, the extremely sandy terrain flies under the wheels, so you often have to go forward on foot on unstable ground where walking is very difficult: wells are very rare, water is in shortage nearly everywhere, even important villages split up into small hamlets or simple *sarés*, spread out on all sides, overlapping in such a way that it is hard to know which chief to address.<sup>147</sup>

The SHMP head saw his role as working with the teams to respond adequately to these different circumstances and he considered it a success when, “little by little lost time was reduced or eliminated...In two or three weeks, the yield was more than doubled.”<sup>148</sup> Officials’ major gaps in understanding of local social and political organization and their concerns about their ultimate ability to reach populations, however, revealed the often severe limitations to their own ability to execute their work. The limits of colonial knowledge would thus, in turn, limit the local implementation of the WHO’s grander program of disease eradication.

At the local level, SHMP teams navigated the incorporation of this new technology of residual insecticides and new type of intervention through the familiar concerns over geographic mobility, speed of work, mediation through Cameroonian authorities, and cooperation by rural populations. Colonial officials framed these new developments on one hand through the colonial geography of the cooperation or non-cooperation of different populations. At the same

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<sup>147</sup> BNF, “La Guerre aux Moustiques,” *Hygiène et alimentation* No. 19-1. Juillet 1953.

<sup>148</sup> BNF, “La Guerre aux Moustiques,” *Hygiène et alimentation* No. 19-1. Juillet 1953.



time, they produced new concerns about the “closed door,”<sup>149</sup> about “fear” of insecticide spraying,<sup>150</sup> or about “inertia” in aiding the teams that hampered the operation.

By contrast, in the arena of World Health Organization meetings, French colonial officials actually became defenders of the Cameroonian population’s varied facilitation of the DDT spraying. There, they argued that any problems experienced in the WHO pilot zone were a result of lack of attention to local circumstances. For example, the Director of the World Health Organization Africa Regional Office expressed concern over progress in the pilot zone due to Cameroonians’ reactions:

Since the second year of operations, the campaign has been faced with a major psychological and social difficulty resulting from the specific characteristics of this African community. Insecticide spraying calls for the observation of a very rigid quarterly or bi-annual spraying schedule. The first enthusiasm wore off as the population discovered that the spraying procedure had to be repeated regularly, leading to a marked reticence and finally to complete refusal to collaborate: the visits of the spraying teams were greeted with an increasingly high percentage of ‘closed doors’. In order to evaluate the importance of this new psychological problem, the WHO sanitary technician made a survey in 18 villages of the pilot zone and reported that only 42.4% of the houses had been treated according to plan. As for the remainder, 41.7% were insufficiently treated, and 15.9% did not receive any treatment at all. Contrasting with the genuine enthusiasm of the inhabitants of treated areas at the onset of operations, this reaction probably is characteristic for certain groups and has to be taken into consideration when treatment is begun; the people resent the repeated visits of the spraying teams which in their minds cause unnecessary disturbance.<sup>151</sup>

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<sup>149</sup> The ‘closed door’ problem continued throughout the 1950s. R. Chastang, « Quatres Années de Lutte Anti-Paludique au Cameroun Méridional, » *Médecine Tropicale : Revue du Corps de Santé Coloniale* 19 (1959), 62. Chastang was Chef de la Section ‘Paludisme’ du SHMP du Cameroun.

<sup>150</sup> NAC 1AC 3506, Le Chef de Subdivision, R. Bluzat, *Rapport Annuel 1957*, Lolodorf, le 25 Février 1958. “Une équipe mobile du S.H.M.P. a fait une tournée de deux mois, dans la Subdivision et a visité de nombreux villages, même ceux de pistes inaccessibles aux véhicules. En général l’équipe a été bien accueillie, mais trop nombreux sont encore les villageois qui refusent le traitement au D.D.T. ou à la Dieldrine de crainte qu’il ne fasse périr chats et volailles et pourrir la toiture.”

<sup>151</sup> World Health Organization Library, Regional Committee for Africa, Sixth Session, Luanda, 24-19 September 1956, *Annual Report of the Regional Director, 1 July 1955-30 June 1956*, AFR/RC6/3, 33.

In a meeting of the WHO Regional Committee for Africa, Dr. Louis Paul Aujoulat<sup>152</sup> meanwhile defended against these comments and asserted that he did not share the same ‘pessimism’ about the chances of success of the malaria campaign in Cameroon. Having himself been in charge of the negotiations for the project on behalf of the French government, he took a special interest in the project. He argued that the ‘closed doors’ of the campaign did not represent a spirit of opposition but rather practical considerations which the teams had not sufficiently taken into account. Noting that the principle activity of this region was cocoa cultivation, he observed that this required intensive work during certain seasons, causing men and women to leave their houses early in the morning and come home late at night. He remarked, “If the teams charged with spraying go to villages during normal working hours, they won’t find anyone because, for Africans, cocoa comes before DDT.”<sup>153</sup> The WHO’s observation of mobile team work thus created new dynamics in talking about their challenges and success, with colonial officials suggesting that the percentage of intervention was not only an index of cooperation by Cameroonians, but also one of success in adapting to local circumstances. This stance was a self-serving one; it bolstered the claim by French officials that their work in Cameroon would most efficiently serve the ideals of international organizations.

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<sup>152</sup> In addition to being a doctor, Aujoulat was a prominent political figure in Cameroon in the 1940s and 50s. He served in the Cameroon Assembly and co-founded the Catholic Mission Society *Ad Luceum*. In 1951 he founded the political party *Bloc Democratique Camerounaise* (BDC). For a biographical sketch, see: Mark W. DeLancey and H. Mbella Mokeba, ed., *Historical Dictionary of the Republic of Cameroon*, 2<sup>nd</sup> edition (Metuchen, NJ and London: The Scarecrow Press, 1990), 31. See also: Guillaume Lachenal and Bertrand Taithe, « Une généalogie missionnaire et coloniale de l’humanitaire : Le cas Aujoulat au Cameroun, 1935-1973, » *Le mouvement social* 227, no. 1 (2009) : 45-63.

<sup>153</sup> Archives Nationales d’Outre-Mer. Aix-en-Provence, France (ANOM) AP 1400, *Comité Régional de l’Afrique, Sixième Session, Luanda, 24-29 Septembre 1956, Procès-Verbal de la Première Séance*, 9.

## **1955: Malaria Eradication and the Politics of Trusteeship**

With the international pilot zone and the broader house-spraying campaigns underway, 1955 marked a turning point in which the French colonial government of Cameroon would create new opportunities to highlight the territory as an important site of international health work, as well as displaying its malaria eradication program as a marker of its progressive colonial rule. At the same time, this year became a decisive turning point in the development of nationalist opposition politics. A nationalist political party, the *Union des Populations du Cameroun* (UPC), mounted violent protests in Douala in that year and the colonial government subsequently banned the party. The UPC appealed to the UN in calling for immediate independence from France based on Cameroon's special status as a Trusteeship. In the context of these two different forms of lobbying of the United Nations, the French government of Cameroon used the malaria eradication program as one way to make a case about public health being an area in which it was on the right side of international cooperation. The implementation of a global health program through the colonial medical system thus created an avenue through which the French government would ultimately defend the maintenance of its colonial governance during a contentious and violent time in Cameroon.

One of the primary ways that the French government highlighted international health work in Cameroon in 1955 was through the hosting of a training course on malaria. As was intended by its original creation, the pilot zone in 1955 became the host site for an international training course on malaria prevention in Africa co-organized by the WHO, the French government and the colonial medical service in Cameroon. Colonial medical officials from across Africa traveled to Yaoundé with the support of WHO grants to participate in an intensive seven-week malaria-training course from mid-February to early April 1955. Dr. Morin directed

the course and scientists from a variety of countries provided lectures on various topics on the science of malaria as well as techniques for combatting it; the pilot project near Yaoundé served as the site for field training.<sup>154</sup>

Colonial officials in Cameroon framed the significance of the course in two main ways. First, they upheld Cameroon as special site, politically emblematic of the spirit of international coordination and notable for the specialized research on malaria happening in the territory. George Spénale, director of the cabinet of the High Commissioner of Cameroon, gave a speech on the opening day of the course in which he thanked the Director of the Africa Office of the WHO for supporting holding the malaria course in Cameroon, arguing that it could not be a better choice, ‘symbolically or practically’:

Symbolically, because this international French-language course could not have a more appropriate site than Cameroon, land of the French Union and of international charter. Practically, because we have ongoing at this moment, on the initiative and with the support of the WHO, two large anti-malaria initiatives..”

Second, officials emphasized the ‘universality’ of the pursuit of science and medicine that the course represented. Dr. Vaisseau, Director of Public Health for Cameroon, opened the first session of the course focused on the significance of the gathering of international scientists and doctors:

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<sup>154</sup> Participants attended from Angola, Cape Verde Islands, French Equatorial Africa, French Togoland, French West Africa, Italian Somaliland, Liberia, Madagascar, Mozambique and the Zone of the Spanish Protectorate in Morocco, along with three participants from French Cameroon. Lecturers from the course came from France, Belgium, Haiti, Italy, Portugal and the United Kingdom. World Health Organization Library, *World Health Organization Regional Committee for Africa, Annual Report of the Regional Director, July 1 1954-30 June 1955*, 23-24. France. *Rapport Annuel du Gouvernement Français Aux Nations Unies Sur l'Administration du Cameroun placé sous la tutelle de la France*, 1954, 192. France. *Rapport Annuel du Gouvernement Français Aux Nations Unies Sur l'Administration du Cameroun placé sous la tutelle de la France*, 1954, 24.

..the international course that will bring together in Yaoundé technicians from seven different countries demonstrates once again that health is indivisible, that disease does not know borders; it is further evidence of this spirit of universality that inhabits and animates all those who belong to the great medical and scientific family.<sup>155</sup>

Spénale reiterated this contextualization of the malaria course in the framework of universality, embodied in the idea of apolitical scientific pursuits, but he also contrasted this significance of the course with the political context of rising nationalist movements within Cameroon and across the continent, casting such politics as essentially parochial in nature:

In such an age, where the old dogma of independence loses each day a bit of its mystical and murderous value, in favor of notions, at once restrictive and generous of cooperation, of solidarity, of interdependence, any meeting of men who, over the mesh of borders, across linguistic and national boundaries, assemble for a constructive exchange of knowledge, ideas and techniques, constitutes promise, merits sympathy, awakens hope.<sup>156</sup>

Spénale continued to connect the specific challenges of the campaign against malaria, and its necessary confrontation with “local diversities,” such as those between the north and south of Cameroon, which those assembled through the course would seek solutions to overcome through “common faith” and “common will.” Spénale moreover expressed “envy,” as a non-medical official, at the “certainty” that those participating in the malaria course could feel about the value of their work.<sup>157</sup> Colonial officials in Cameroon thus connected the work of the

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<sup>155</sup> ANOM Bibliothèque 22671 « Le Cours International de Paludologie de Yaoundé, » *Haut-Commissariat de la République Française au Cameroun, Service de l'Information, Bulletin d'Information et de Documentation*. No. 89, (28 Février, 1955), 7.

<sup>156</sup> ANOM Bibliothèque 22671 « Le Cours International de Paludologie de Yaoundé, » *Haut-Commissariat de la République Française au Cameroun, Service de l'Information, Bulletin d'Information et de Documentation*. No. 89, (28 Février, 1955), 9.

<sup>157</sup> ANOM Bibliothèque 22671 « Le Cours International de Paludologie de Yaoundé, » *Haut-Commissariat de la République Française au Cameroun, Service de l'Information, Bulletin d'Information et de Documentation*. No. 89, (28 Février, 1955), 10. « Protéger, contre un fléau endémique traditionnel, de vastes régions et des tribus sans

malaria pilot zone—as both a site of international research and training—to a characterization of French Cameroon as being a place that fostered the international health ideals of a universal striving towards human betterment.

Over the term of the malaria course, SHMP personnel also played a central role in coordinating the field experiences of the participants. The doctors participating in the malaria course visited Maroua in northern Cameroon to learn about the insecticide-spraying program in that region and to compare the work in the northern region with that in the pilot zone. Dr. Paclisanu, the head doctor of the SHMP in the area, worked with the *lamido* (the name for a Fulani head of an administrative unit in the north) of Bogo to facilitate having the course participants examine children in villages that had been treated or not treated with the insecticides, seeking to determine the rate of malaria. The possibility of this ‘field experience’ thus relied on the practices of intervention of the SHMP, of using traditional authorities as intermediaries, and allowed international medical personnel to examine children in a one-time event that would have no clear bearing on the pursuit of malaria eradication in the area. Dr. Paclisanu even housed some of the course participants at his own home.<sup>158</sup> The structure, operations and personnel of the SHMP thus facilitated the ability of a cadre of international health personnel to travel to a new place in Cameroon and partake in something as invasive as the physical examination of children.

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défense scientifique, est une tâche qui confère, à tous ceux qui s’y emploient, la certitude d’œuvrer constamment dans le sens du mieux-être de l’homme, du bien social. »

<sup>158</sup> ANOM Bibliothèque 22671 « Le Cours International de Paludologie de Yaoundé : les Stagiaires de l’OMS Viennent d’Effectuer un Voyage d’Etudes à Maroua » *Haut-Commissariat de la République Française au Cameroun, Service de l’Information, Bulletin d’Information et de Documentation* 9 (Mars 31 1955), 38-39.

The French colonial government also used the malaria course as an opportunity to defend and paint a flattering portrait of its work in Cameroon, representing it as a place that was properly engaged in international cooperation. The official press outlet of the High Commissioner of Cameroon reported on the visit of the course to the north in March 1955, highlighting the international character of the delegation visiting the north and the helpful interventions of Dr. Paclisanu. The government also highlighted the course and the general work in the pilot zone in the required annual reports to the UN. In 1954, the annual report to the UN on the Trusteeship included information on the “meticulous organization” underway to plan for the course.<sup>159</sup> In 1955, the French reported on the malaria course in the annual report under the heading of “Cooperation with the UN and the Specialized Bodies.”<sup>160</sup> In October of 1955, the colonial government further highlighted the anti-malaria campaign when the UN Trusteeship Council visited Cameroon to make direct observations about French administration. The international delegates of the UN ‘assisted’ with a demonstration of DDT spraying in a northern village near Mokolo.<sup>161</sup> While the French government strove to paint a portrait of progressive developments in the UN, particularly in the realm of health, the malaria program was one particular way that it not only defended its colonial governance but also connected this administration to the development of international coordination around health. The program thus became further implicated in colonial administration in Cameroon by creating a new

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<sup>159</sup> France. *Rapport Annuel du Gouvernement Français Aux Nations Unies Sur l'Administration du Cameroun placé sous la tutelle de la France*, 1954, 192.

<sup>160</sup> France. *Rapport Annuel du Gouvernement Français Aux Nations Unies Sur l'Administration du Cameroun placé sous la tutelle de la France*, 1955, 24.

<sup>161</sup> ANOM Bibliothèque 22671 « La Mission de Visite de l'O.N.U. dans La Nord-Cameroun » *Haut-Commissariat de la République Française au Cameroun, Service de l'Information, Bulletin d'Information et de Documentation*, (29 Octobre 1955), 11.

avenue for France to attempt to justify, on an international stage, its ongoing control of Cameroon.

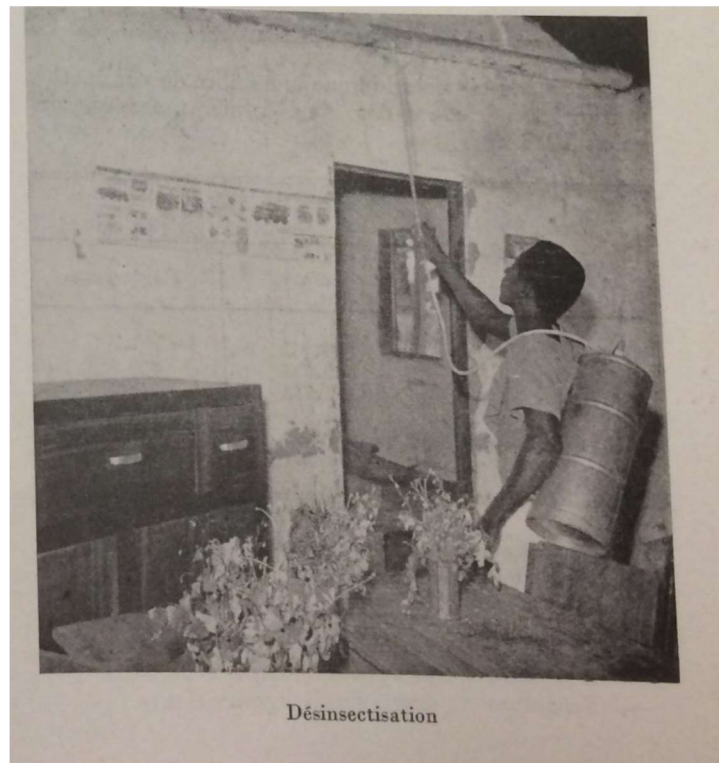


Photo of malaria campaign included in French report to the UN. *Rapport Annuel du Gouvernement Français à L'Assemblée Générale des Nations Unies sur l'Administration du Cameroun Placé sous la Tutelle de la France, Année 1954*

Only a few short weeks after the conclusion of the malaria course, the political climate in Cameroon would meanwhile take a significant turn with the increasingly visible opposition mobilized by the *Union des Populations du Cameroun*. Founded in 1948, the party emerged as a radical nationalist party that called for immediate independence from France.<sup>162</sup> Facing increasing repression from French authorities, the UPC launched a series of volatile protests in

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<sup>162</sup> Richard Joseph, *Radical Nationalism in Cameroon: Social Origins of the U.P.C. Rebellion* (Oxford, New York: Clarendon Press, 1977). On the UPC, see also: Achille Mbembe, *La Naissance du Maquis dans le Sud-Cameroun (1920-1960) : histoire des usages de la Raison en colonie* (Paris: Karthala, 1996).



Douala in May 1955. In July, the colonial government subsequently banned the party in Cameroon.

Part of the strategy of UPC leaders in the 1950s was to leverage the existence of the Trusteeship to make claims to the UN about human rights violations under colonial rule.<sup>163</sup> Thousands of UPC members submitted petitions to the UN General Assembly and to the Trusteeship Council to denounce French rule. Some members of the UPC used petitioning to the UN to express their unease and fear with regard to the French administration of public health and medicine.<sup>164</sup> While the UPC's engagement with the UN began in years prior, Meredith Terretta has shown that from 1955 onward, the UPC nationalist platform and strategy specifically connected local conceptions of politics and sovereignty to the global politics of decolonization.<sup>165</sup>

The connections that colonial health officials drew with the UN and the WHO through the malaria eradication program thus stood in direct contrast to how members of the UPC leveraged international connections, international institutions, and their own transnational mobility as a form of political power.<sup>166</sup> As French colonial officials worked, through UN reports and UN mission visits, to positively portray French rule under Trusteeship, they also crafted a message about the connections between their governance and international health that focused on Cameroon's ability to be a site of international health intervention and experience.

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<sup>163</sup> Meredith Terretta, "We Had Been Fooled into Thinking that the UN Watches over the Entire World": Human Rights, UN Trust Territories, and Africa's Decolonization," *Human Rights Quarterly* 34. 2 (2012): 329-60.

<sup>164</sup> Meredith Terretta, *Nation of Outlaws, State of Violence: Nationalism, Grassfields Tradition, and State Building in Cameroon* (Athens: Ohio University Press, 2014), 5.

<sup>165</sup> Meredith Terretta (2014), 4. Terretta, "Cameroonian Nationalists go Global: From Forest *Maquis* to a Pan-African Accra," *Journal of African History* 51 (2010): 189-212.

<sup>166</sup> Terretta 2010.

Colonial medical officials thus produced a new framework of international health in Cameroon, not only through new resources and through the integration of WHO personnel into medical and scientific networks on the ground, but also through these efforts to present public health in Cameroon as progressive and in line with a conception of medicine and science as global and universal. French officials connected the malaria campaign's rootedness in specific locales—in the pilot zone of Yaoundé and in the villages of northern Cameroon, and in the specificity of Cameroon as a Trusteeship- to the grander goals of global disease coordination and eradication. This political framing of the malaria program also relied on a conception of mobility—of experts and ideas—between the local, the colonial and the international.

### **Eradication Hopes and Decolonization**

As the insecticide-spraying program continued, the WHO continued to send malariologists to work out of Yaoundé, but the SHMP took an increasing role in controlling the overall program, including the Yaoundé pilot zone. With this progression, the program became more integrated into the structure of the SHMP itself, and the distinction between the operational work of the Yaoundé pilot zone and the broader malaria program in the south more indistinct. This progression occurred in the context of the broader political changes in the later 1950s that would ultimately lead to Cameroon's political independence. Through these intertwining changes, SHMP doctors ultimately positioned themselves as key intermediaries of Cameroon's international health engagements as the country became independent.

This transition first began through the SHMP's own restructuring, as it began to assign more personnel to focus specifically on malaria. The Cameroon SHMP created plans in 1955 to establish a specialized malaria service within its organizational structure. A SHMP doctor would oversee the service, assisted by deputy doctors in both the southern and northern zone

and a sanitary technician. This service would provide quality control for the malaria program—including oversight of house-spraying, collection of blood samples and of mosquito sampling.<sup>167</sup> Médecin-Commandant Jean Languillon served as the first head of the malaria section of the Cameroon SHMP.<sup>168</sup> The SHMP thus now had a main person of contact, beyond the head of the SHMP service, with whom the WHO and UNICEF could work.

The arrival of the third WHO malaria expert to Yaoundé led to further changes that diminished this role to the overall control of the program by the SHMP. Professor Gregory Livadas, a malaria expert of Greek nationality, arrived in Yaoundé in 1957.<sup>169</sup> Livadas met with the head of the SHMP, now Médecin-Colonel Feyte, and with Dr. Languillon and the three devised a new plan of operations for the pilot zone. This need for a new plan of operations grew in part from the insufficient coverage achieved by the spraying campaigns in the pilot zone; by 1957, spraying teams had only reached 50-60% of the intended population.<sup>170</sup> Thus, going forward, Livadas would play a “purely consultative” role in his position as the WHO representative. The personnel of the SHMP malaria section would be assigned to work in the pilot zone and Languillon, would “assure the direction of these operations which will be carried

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<sup>167</sup> SHD 2013 ZK 005 317, *Recommandation du Directeur Général pour une affectation de crédits à L'Afrique Occidentale Française, Cameroun et Togo pour la campagne anti-paludique au Cameroun*, Fonds des Nations Unies Pour l'Enfance, Comité du Programme, 14 février 1955.

<sup>168</sup> Languillon subsequently became director in 1956 of the newly created medical research center in Yaoundé, *Institut de Recherches Médicales du Cameroun* (IRCAM), which later became the Pasteur Institute of Cameroon. Guillaume Lachenal, “Franco-African Familiarities. A history of the Pasteur Institute of Cameroun, 1945-2000,” in *Hospitals beyond the West: from Western Medicine to Global Medicine*, edited by Mark Harrison and Belinda White (Orient-Longman: New Dehli, 2009), 420.

<sup>169</sup> H. Morin served in the position from 1953-1955; Dr. L. Najera from 1955-1957, and Professor Livadas arrived in 1957.

<sup>170</sup> Jean-Paul Bado, « Un Regard d'Historien sur la Lutte contre le paludisme au Cameroun (1950-1960), » in *Sociétés, environnements, santé*, ed. Nicole Vernazza-Licht et al. (Marseille : IRD Éditions, 2010), 342.

out according to the recommendations of Professeur Livadas.”<sup>171</sup> A 1957 SHMP report on the malaria program referred to the Yaoundé pilot zone as the “former WHO pilot zone.”<sup>172</sup>

Following the reorganization of the pilot zone, spraying teams undertook an intensified and punishing schedule to achieve a better coverage with insecticides.<sup>173</sup> The outcome of this intensified program produced a seeming breakthrough in the pursuit of malaria eradication. At a conference on tropical medicine and malaria in 1958, Livadas, R. Chastang, the new head of the malaria section of the SHMP, and co-researchers reported that while “the possibility of the eradication of malaria in Tropical Africa is the object of numerous controversies,” results in the Yaoundé pilot zone showed that it was possible.<sup>174</sup> They reported that in Yaoundé, at the center of the pilot zone, that transmission of malaria had been successfully interrupted.

The broader house-spraying campaigns in the south and north did not yield equally promising results. The southern program also suffered from insufficient coverage by the teams; the teams’ travel became dependent on the existence of pathways navigable by vehicle and this

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<sup>171</sup> World Health Organization Archives, Geneva, Switzerland (WHO) M2/418/2, “Rapport d’Ordre General Sur la Campagne Antipaludique au Cameroun” 15 November 1956-15 Mai 1957. Languillon and Livadas also reorganized the structure or insecticide use in the pilot zone in 1957. Whereas previously the zone had been focused on the use of the three insecticides, DDT, HCH and Dieldrine. In 1957, they divided the zone into two areas, one of which would be treated with DDT and the other with Dieldrine. They also expanded the space that the pilot zone would encompass to include a total of 120,000 people. Bado, 342.

<sup>172</sup> WHO M2/418/2, “Rapport d’Ordre General Sur la Campagne Antipaludique au Cameroun” 15 Novembre 1956-15 Mai 1957.

<sup>173</sup> Bado (2010), 343.

<sup>174</sup> WHO M 2/418/2, G. Livadas, J. Mouchet, J. Gariou, R. Chastang, « Peut-on envisager l’éradication du paludisme dans la région forestière du Sud Cameroun, » Communication présentée aux VI Congrès de Médecine Tropicale et du Paludisme (Lisbonne Septembre 1958). Mouchet was an entomologist for the malaria program, working through ORSTOM (*Office de la Recherche Scientifique et Technique Outre-Mer*). Dr. J. Gariou was head of the *Laboratoire d’Entomologie Médicale de Yaoundé*.

left at least 200,000 people intended to receive house-spraying outside of its domain.<sup>175</sup> WHO officials meanwhile described results in the north as “slow and disappointing.” French, UNICEF and WHO representatives decided in 1957 to subsequently reorganize this aspect of the Cameroon program with new trials of insecticides as well as of anti-malarial drugs.<sup>176</sup>

As the SHMP further absorbed the direction of the malaria program, legislative changes extending across the French empire in Africa created new political arrangements with implications for how the functioning of international health programs would continue. The *loi cadre* of 1956 invested new political authority in Cameroonians through the creation of a single elector college and new legislative assembly, led by a prime minister and cabinet of ministers. Thus, for the first time in 1957, the territory had a Cameroonian Minister of Public Health, Haman Adama.<sup>177</sup> One of the objectives of the *loi-cadre* was to place responsibility for a territorial budget to Africans, while allowing the French to maintain control of essential areas of governance including defense and foreign affairs.<sup>178</sup> Thus while the new territorial assembly could pass laws regarding health, the French maintained control over workings with international health institutions.

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<sup>175</sup> WHO M 2/418/2, G. Livadas, J. Mouchet, J. Gariou, R. Chastang, « Peut-on envisager l'éradication du paludisme dans la région forestière du Sud Cameroun, » Communication présentée aux VI Congrès de Médecine Tropicale et du Paludisme (Lisbonne Septembre 1958).

<sup>176</sup> WHO Library, *Annual Report of the Regional Director to the Regional Committee for Africa, Tenth Session: 1 July 1959-31 March 1960*. AFR/RC 10/3, 102.

<sup>177</sup> Martin Atangana, *The End of French Rule in Cameroon* (Lanham, Maryland: University Press of America, 2010), 41. Adama, an auxiliary veterinary nurse, appears to have been primarily a political appointee, without extensive medical training. He was a member of the political party, the *Groupe d'Union Camerounaise*. In 1957, Ahmadou Ahidjo, who became the first president of Cameroun, served as the chairman of the party and the Vice-Prime Minister in the territorial assembly (ALCAM-Assemblée Législative du Cameroun). On Adama, see also: Fernand Merle, *Un Voyage au Long Cours: Les aventures d'un médecin outre-mer* (Paris : Albin Michel, 1984), 133.

<sup>178</sup> Tony Chafer, *The End of Empire in French West Africa: France's Successful Decolonization* (Oxford: Oxford International Publishers, 2002), 166.

The WHO and UNICEF in turn noted the legislative developments of 1957 as bringing little change to their dealings with Cameroon. A UNICEF document in 1957 detailing funding that the agency would provide to Cameroon outlined these political changes and the implication of these changes for health administration and dealing with international institutions. First, it noted that it was imagined that “the SHMP will continue to function for several years as it has in the past.”<sup>179</sup> Second, it noted that while the newly elected Territorial Assembly would have power over various internal legislative matters, France would continue to control Cameroon’s “relations with the outside world.”<sup>180</sup>

UNICEF representatives furthermore reinforced this arrangement in its dealing with the Cameroonian Minister of Health. In September 1957, a UNICEF representative responded to a request that Minister of Health Adama had sent for more insecticide to use for an expansion of the malaria program in Cameroon. The UNICEF representative explained that the organization was unable to fulfill the request but also noted that he was sharing this point of view “unofficially”; he stated that any official request for assistance had to come through the French *Ministère d’Outre-Mer*.<sup>181</sup> Thus even as Cameroonians took some control over internal affairs, French officials guarded their role as intermediaries between the Cameroonian government and international institutions.

SHMP leadership meanwhile broadened its privileged connection to international health institutions. When the health agencies of the UN decided in 1957 to provide funding for leprosy

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<sup>179</sup> NAC VT 7-106, Fonds des Nations Unies Pour l’Enfance E/ICEF/L. 1075 25 Juillet 1957, Annex 1, 1.

<sup>180</sup> NAC VT 7-106, Fonds des Nations Unies Pour l’Enfance E/ICEF/L. 1075 25 Juillet 1957, Annex 1, 1.

<sup>181</sup> NAC VT 7-106, R. Marti, Représentant en Chef du FISE, Bureau Central pour l’Afrique à Monsieur le Ministre de la Santé Publique au Cameroun, Brazzaville, le 17 Octobre 1957.

work in Cameroon, the head of the SHMP created the accords with WHO and UNICEF. Minister of Health Haman Adama transmitted these plans to the Cameroonian Prime Minister, André-Marie Mbida, noting that the accords followed the same general structure as those used for the malaria campaign.<sup>182</sup> The role of Cameroonian officials in shaping these campaigns from a legislative perspective thus remained limited. The limited number of Cameroonians medically trained at the same level as French physicians certainly compounded this situation. Adama's role as the Minister of Health marked a political appointment. Dr Fernand Merle, who became the head of the SHMP in the final years of the 1950s wrote retrospectively about this time that the Cameroonian government knew that, despite the naming of a health minister, the work of the of administration would *really* be done by him, with regards to mobile health, and another French military doctor for fixed medicine.<sup>183</sup>

The Cameroonian who began and continued to play the most powerful role in Cameroon's internal and external relations of health was Dr. Simon-Pierre Tchoungui. One of the earliest Cameroonian recipients of the doctorate in medicine in France, Tchoungui began to carve out a key role as intermediary for international health organizations in the late 1950s. In 1959, the Ministry of Health created a Service of International Relations to deal with external health organizations, and Tchoungui became its head. In 1961, he became Cameroon's Minister of Health.<sup>184</sup> Having trained in the French system and maintained close professional ties with

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<sup>182</sup> NAC VT 7-106, H. Adama, Le Ministre de la Santé Publique (Direction du Cabinet) à Monsieur le Premier Ministre Chef du Gouvernement Camerounais. Yaoundé. No date.

<sup>183</sup> Merle, 134.

<sup>184</sup> Tchoungui obtained the doctorate in medicine in France in 1956. Ndam, 57, 88. WHO Library, *Les Services de la Santé Publique au Cameroun en 1959*. Yaounde, Juillet 1960.

French doctors, he helped to facilitate their ongoing prominence even as he developed his own position of authority.<sup>185</sup>

Meanwhile, the political unrest gripping southern Cameroon created an uncertain and volatile backdrop for the mobile teams trying to continue the intrusive work of going into people's homes and spraying insecticide. During the final years of the 1950s, the ability of teams to do this work in Sanaga Maritime, a central base for UPC activity, remained highly unpredictable.<sup>186</sup> European managers of the teams often feared going to more remote areas, for fear of running into hideouts of the UPC *maquisard*.<sup>187</sup> Many Cameroonians on the mobile teams also feared the region and refused to work there. In 1958, Cameroonians on the mobile team in charge of house-spraying in Sanaga Maritime wrote to the Minister of Health and requested a raise in their salary before going to the region for their work. They wrote that "without it, we will not go," citing that they had worked hard despite fearing for their lives.<sup>188</sup> The SHMP Director, Médecin Colonel Feyte, sent a letter of support for the request to the Minister of Health, noting that "while other teams had refused to work" in Sanaga Maritime, the members of this team had continued "often under the protection of military escorts."<sup>189</sup>

Yet, while the unrest in Sanaga Maritime posed challenges for the SHMP, the service also benefited from the repressive counter-measures enacted by French authorities against the

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<sup>185</sup> Lachenal (2006).

<sup>186</sup> Chastang, 72.

<sup>187</sup> Bilounga, 35.

<sup>188</sup> NAC, VT 7-106, Copie d'une requête en date du 20 Septembre 1958 des personnels de l'Equipe no.1/D chargé de la désinsectisation en Sanaga Maritime.

<sup>189</sup> NAC, VT 7-106, Le Médecin Colonel Feyte, Chef du Service d'Hygiène Mobile à Monsieur le Ministre d'Etat chargé de la Santé Publique et de la Population. Yaoundé, le 29 Septembre 1958.



UPC. Beginning in 1957, French and Cameroonian troops forcibly relocated entire villages to areas directly along roads and railroad lines in an effort to surveil and control the population.<sup>190</sup> Dr. Chastang, the head of the SHMP malaria section, wrote that this set up was “ideal for the teams” since it allowed them to move much more quickly in spraying homes.<sup>191</sup> The facilitation of a public health program by colonial repression was not, in itself, unique to colonial Cameroon. Yet, in this particular time in Cameroon, as the UN Trusteeship Council encouraged a trajectory for Cameroon towards self-governance, it was colonial coercion in Sanaga Maritime that facilitated public health work in service of the WHO’s ideal of a global eradication of malaria. This scenario thus highlighted two sides of a relationship between colonialism and postwar internationalism—one at odds over the political vision of Cameroonian independence and another in synchrony over the desire to pursue public health programs with a focus on outcome, regardless of Cameroonian political will.

When French Cameroon ultimately gained political independence in January 1960, the French doctors of the SHMP continued to play a central role in the malaria program. This arrangement reflected the strong hand that France maintained in Cameroon after independence, as it did across most of its former colonies in Africa. Formal independence thus marked only a partial change in Cameroonians governing their external dealings on health. In 1960, Cameroon notably became a member of the World Health Organization, as it would of other international organizations. At the same time, however, French military doctors continued to maintain leadership positions within the SHMP and thus, maintained a central role in the

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<sup>190</sup> Martin Atangana, *The End of French Rule in Cameroon* (Lanham, Maryland: University Press of America, 2010), 63. This ‘regroupement’ was part of Cameroon High Commission Pierre Messmer’s creation of a ‘pacification’ zone meant to destroy the UPC, known as ZOPAC (Zone de pacification du Cameroun).

<sup>191</sup> Chastang, 73.

planning of the malaria program and interactions with international health officials.<sup>192</sup> On February 17, 1960, representatives from the Cameroonian government, from the WHO and from UNICEF met to discuss the future for the Yaoundé pilot zone, in light of its encouraging results in interrupting malaria transmission. The Cameroonian delegation included two French military doctors still holding leadership posts within the SHMP. In addition to Cameroonian Dr. Simon-Pierre Tchoungui, Dr. Merle, the head of the SHMP and Dr. Chastang, head of the malaria section of the SHMP, joined the meeting.<sup>193</sup> Thus, international health organizations continued to engage with a ‘Cameroonian government’ on issues of health that involved French doctors in essential ways.

At this meeting, the health officials made the important decision to change course in light of the interruption of malaria transmission in the pilot zone. The Yaoundé pilot zone was one of only two sites in Africa where malaria transmission had been successfully interrupted, and it thus presented a site of major importance for the larger question about the possibility of eradication on the continent.<sup>194</sup> The health officials in this meeting decided to suspend house-spraying in the pilot zone and they created a plan for surveillance of malaria rates.<sup>195</sup>

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<sup>192</sup> Chapter 2 will further explore how this phenomenon related to international health. Guillaume Lachenal’s work also examines Franco-Cameroonian ties through independence in the realm of science and medicine. (2009, 2013).

<sup>193</sup> WHO, M 2/372/3 (b) Came. Jackets 1+2, *Rapport Final par Professeur Dr G.A. Livadas, Consultant Paludologue O.M.S., Zone Pilote d’Essai de Yaounde*, 26 Avril 1960, 6.

<sup>194</sup> The other site where transmission was temporarily interrupted was in Liberia. Leonard J. Bruce-Chwatt, “Lessons learned from applied field research activities in Africa during the malaria eradication effort,” *Bulletin of the World Health Organization* 62 (1984), 19.

<sup>195</sup> WHO, M 2/372/3 (b) Came. Jackets 1+2, *Rapport Final par Professeur Dr G.A. Livadas, Consultant Paludologue O.M.S., Zone Pilote d’Essai de Yaounde*, 26 Avril 1960, 6.

The optimism about malaria eradication produced by the pilot zone results was, however, quickly destroyed. After the cessation of house spraying in the pilot zone, Cameroonians in the area experienced a major resurgence of malaria, with the disease appearing at rates rarely recorded.<sup>196</sup> Other pilot projects across Africa that had lowered malaria rates through the use of insecticides likewise saw an increase in the disease after the projects ended.<sup>197</sup> The failure of the malaria pilot projects showed that residual insecticides like DDT could successfully reduce, but could not eradicate, malaria in tropical Africa. Moreover, they showed that insecticides were not a viable long-term solution to controlling malaria, as instances of mosquito species that transmitted malaria becoming resistant to the insecticides were reported.<sup>198</sup> Moreover, health officials had treated the pilot projects operating in Africa as containable, discreet geographic spaces and had vastly underestimated the mobility of Africans both within and across territorial boundaries.<sup>199</sup> When the WHO's entire goal of global malaria eradication ultimately failed, it became clear that health officials had failed to account for the complexity of the disease and had put too much faith in technical solutions to problems that also had social determinants.<sup>200</sup> In the 1960s, Cameroonian health officials would eventually work with the WHO plans for 'pre-eradication' of malaria through the development of basic health services, a development that chapter 5 will discuss further.

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<sup>196</sup> Webb (2014), 90.

<sup>197</sup> Webb (2014), 88.

<sup>198</sup> Webb (2014), 95.

<sup>199</sup> Webb (2014), 93-94.

<sup>200</sup> Stepan, 182. Randall Packard, *The Making of a Tropical Disease: A Short History of Malaria* (Baltimore, MD: Johns Hopkins University Press, 2007).

Thus, although malaria eradication failed in Cameroon, as it did everywhere in the world, it was through the program that Cameroonian, French and international health officials forged and adapted new operational relationships in the postwar context. Because the malaria program relied on the operations of the mobile health teams, it became part of the SHMP's particular practices of rural health intervention and organizational structure. As this chapter has shown, the malaria program became inscribed in local workings of the SHMP, for example of health officials working through Fulani *lamido* or through the attempts by colonial officials to control the population of Sanaga Maritime. Thus while the malaria program connected to the ambitious program of global malaria eradication, the operations of the program worked within these colonial parameters.

The significance of this convergence between global disease eradication and colonial medicine within Cameroon was two-fold. First, the public health interventions that Cameroonians experienced as part of the malaria program were part of their interactions with the SHMP. While the nature of the medical intervention certainly changed, the basic structures of the mobile teams appearing for time-limited visits to perform targeted interventions remained. Cameroonians' reactions varied widely across regions and some welcomed, just as some actively resisted, these interventions. Most significantly, the creation of the WHO and its espoused ideals of apolitical internationalism in the realm of health did not change the type of public health interventions that Cameroonians experienced in the 1950s. They ultimately experienced new technologies within the framework of the colonial medical system.

For French colonial officials, however, the WHO and its support of the malaria campaigns created new opportunities in terms of medical resources as well as in terms of political capital. This chapter has shown how French officials used the malaria eradication

program to defend their rule to the UN and to promote their place in Cameroon as champions of health internationalism. The positions of authority that the French SHMP officials assumed through the malaria eradication program also ultimately positioned them as intermediaries of the new resources for health work stemming from the creation of the specialized technical agencies of the United Nations. As they guarded this role through the final years of the 1950s and through political independence, they positioned themselves, with the support of Cameroonian elites, to continue to play a central role in the operation of international health programs in the 1960s. The work of the mobile health teams in shaping the malaria eradication program in the 1950s thus created the parameters through which health officials of independent Cameroon would negotiate the relationships of international health.

## **Chapter 2: Creating the Health Region: Mobile Health Teams, Decolonization, and the Organization for Coordination in the Fight against Endemic Diseases in Central Africa (OCEAC)**

The independence of French Cameroon in January 1960 did not mark a rupture in the operation of mobile health teams and the work of French military doctors as much as it did a restructuring and a re-imagining of their place in the independent state,<sup>201</sup> as well as their position in international health. The ongoing role of the French in the medical system in Cameroon and specifically in the mobile health team service reflected the broader political context of decolonization in Cameroon, as in other former French colonies in Africa.<sup>202</sup>

Far from a severing of ties at independence, most African states instead engaged in an “intensification of the links with France,” in a system of policies, financial flows and networks of people often referred to as ‘la Françafrique,’ or ‘l’État franco-africain.’<sup>203</sup> Key aspects of this system were the tying of African currencies to the French franc at a fixed rate, the creation of the French Ministry of Cooperation to distribute aid to African countries, and the accords signed between France and individual African governments outlining cultural, military and technical

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<sup>201</sup> I draw here on Lachenal’s framework of independence as a moment when Cameroonians and French constructed a vision for ongoing medical and scientific cooperation. Guillaume Lachenal, “Célébrer le passé, construire le futur: l’indépendance et le microcosme médical au Cameroun,” in *Les Indépendances en Afrique: l’événement et ses mémoires: 1957/1960-2010*, ed. Odile Goerg et al. (Rennes: Presses Universitaires de Rennes, 2013), 353-376.

<sup>202</sup> Guillaume Lachenal. “Franco-African Familiarities. A history of the Pasteur Institute of Cameroun, 1945-2000,” in *Hospitals beyond the West: from Western Medicine to Global Medicine*, edited by Mark Harrison and Belinda White (Orient-Longman: New Dehli, 2009), 411-444.

<sup>203</sup> Tony Chafer, “Chirac and ‘la Françafrique’: No Longer a Family Affair,” *Modern & Contemporary France* 13.1 (2005), 7. For more on the idea of the ‘Franco-African state’: Jean-Pierre Dozon, “L’Etat franco-africain,” *Les Temps Modernes*, 620-621 (2002): 261-88. Dozon argues that a historical perspective on these connections is needed, and he dates the origin of the ‘French-African state’ to World War I due to the conscription of African soldiers and the turn toward greater intervention in the colonies.

cooperation.<sup>204</sup> In Cameroon, this relationship was particularly marked by the ongoing role of French troops in violently suppressing ongoing opposition from the *UPC* to the rise of first president Ahmadu Ahidjo.<sup>205</sup>

The French Ministry of Cooperation (*Coopération*), created in 1959, meanwhile became the new administrator of bilateral aid to former African colonies and ensured an ongoing influx of French people working as technical experts throughout these countries. In 1961, for example, France funded 576 civil servants in Cameroon, 80 of them working in health.<sup>206</sup> The Fund for Aid and Cooperation (*Fonds d'Aide et de Coopération*, FAC) was the main avenue through which France distributed this aid in the form of technical assistance personnel, as well as money for operating budgets and equipment. Between its creation in March 1959 through February 1964, FAC distributed roughly twenty-two and a half million dollars for public health programs across the former African colonies, with about one third of this money going towards campaigns led by the mobile health services.<sup>207</sup> In Cameroon, this proportion was higher, with approximately forty-six percent of FAC public health aid going towards the mobile service.<sup>208</sup>

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<sup>204</sup> Chafer (2005), 9.

<sup>205</sup> Terretta, 2014. Richard Joseph, ed. *Gaullist Africa: Cameroon under Ahmadu Ahidjo* (Enugu, Nigeria: Fourth Dimension Publishing Co. Ltd, 1978). Thomas Deltombi, Manuel Domergue, Jacob Tatsitsa, *Kamerun! Une guerre cachée aux origines de la Françafrique, 1948-1971* (Paris : Découverte, 2010).

<sup>206</sup> David E. Gardinier, *Cameroon: United Nations Challenge to French Policy* (London: Oxford University Press, 1963), 98.

<sup>207</sup> Division of Medical Sciences : National Academy of Sciences, National Research Council, *Public Health Problems in 14 French Speaking Countries in Africa and Madagascar: A Survey of Resources and Needs*, Volume I (Washington, DC, 1966), 38-39. France distributed additional money for public health through the European Development Fund (Fonds européen de Développement, FED).

<sup>208</sup> Division of Medical Sciences : National Academy of Sciences, National Research Council, *Public Health Problems in 14 French Speaking Countries in Africa and Madagascar: A Survey of Resources and Needs*, Volume I (Washington, DC, 1966), 45. From 1959-February 25, 1964, FAC invested \$2,693,000 in public health programs in Cameroon and \$1,238,000 of that went towards “campaigns against endemic diseases,” the work of the mobile health service.

In this period among all of the former French African territories, Cameroon was second only to Chad in the amount of money it received to support the mobile health service.<sup>209</sup>

The distribution of Cameroonian and French medical personnel between the mobile health service and the rest of the medical administration continued to reinforce the particularly stark hierarchies forged during the colonial period within the mobile service. French military doctors continued to dominate the leadership of the service at both the national level as well as at the level of leading each of the fourteen “sectors” designated by the mobile service within the country.<sup>210</sup> The movement of Cameroonian doctors into positions of power did not upend this structure. In 1961, Cameroon gained its first medically trained Minister of Health, Dr. Simon-Pierre Tchoungui, who held a doctorate in medicine from France and thus held equivalent training to French doctors.<sup>211</sup> The majority of more highly-skilled Cameroonian medical personnel at independence remained, however, at the status of *médecin africain* and also continued to work primarily in fixed health posts, such as hospitals and dispensaries. Moreover, roughly half of the Cameroonian *médecin africains* (26) were in France pursuing the doctorate in medicine in 1961.<sup>212</sup> By 1964, even as many of those in training returned to Cameroon, the

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<sup>209</sup> Division of Medical Sciences : National Academy of Sciences, National Research Council, *Public Health Problems in 14 French Speaking Countries in Africa and Madagascar: A Survey of Resources and Needs*, Volume I (Washington, DC, 1966), 45. From 1959-February 25, 1964, FAC invested \$1,360,000 toward campaigns against endemic diseases in Chad. This constituted the majority of FAC public health investment in Chad; the total public health investment came to only \$1,991,000.

<sup>210</sup> These sectors covered only former French East Cameroon, and not the former British territory of West Cameroon.

<sup>211</sup> Dr. Tchoungui attended the Dakar Medical School in the 1940s and later obtained a doctorate in medicine from the University of Paris in 1956. He became Minister of Public Health of Cameroon in 1961 and subsequently held other ministerial posts before becoming Prime Minister of East Cameroon in October 1965. For more biographical detail: DeLancey and Mokeba, 190.

<sup>212</sup> SHD ZK 005 406, « Enquête sur la Coopération Technique en Matière Sanitaire au Congo, Gabon, Centrafrique, Cameroun et Tchad, » 4 octobre-6 novembre 1961, Médecin Colonel Diagne.



seventeen doctors posted to the mobile service were almost all French.<sup>213</sup> The service thus guarded its particular culture and ethos, shaped by the shared French military training of its leaders, well beyond independence.

As France repackaged its avenues of funding for social and economic development to former African colonies, it also delineated new responsibilities with independent Cameroon for the funding of the *Service d'Hygiène Mobile et de Prophylaxie* (SHMP) and its personnel. In July 1960, the fifteen French medical officers and one nurse of the *Service de Santé militaire* serving in the SHMP in Cameroon, as well as the twenty contractual Europeans medical personnel in the service, became funded through the program of 'technical assistance' of *Coopération* for African states. The government of Cameroon would meanwhile take on the charge of salaries for the Cameroonian personnel working for the SHMP.<sup>214</sup>

At the same time, the postwar avenues of international health funding for the SHMP that opened in the 1950s continued in the early 1960s. In addition to funding from the Cameroonian national budget, and the French fund for *Coopération*, the World Health Organization and UNICEF served as the third source of funding for the mobile team service in 1961. The French government meanwhile urged Cameroonian officials to revise agreements with these international organizations in order to move towards equal contributions from the three sources for the SHMP.<sup>215</sup> The negotiation of the place of international health institutions, funding and

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<sup>213</sup> Centre des Archives diplomatiques de Nantes. France. (CADN) 744PO/1/687, Docteurs Guy Ferrand et J.P. Roubier, *République Fédérale du Cameroun : Plan de Santé Publique, Rapport de Synthèse, Septembre 1966*, 42.

<sup>214</sup> CADN 744PO/1/30, *Comité Directeur du Fonds d'Aide et de Coopération, République du Cameroun, Programme F.A.C. 1961*.

<sup>215</sup> CADN 744PO/1/30, *Comité Directeur du Fonds d'Aide et de Coopération, République du Cameroun, Programme F.A.C. 1961*. The 1961 budget for the SHMP broke down to the following contributions: Cameroon: 150 million Franc CFA, France: 104.5 million CFA, OMS/UNICEF: 32.9 million CFA.

personnel thus became an immediate and central part of how both Cameroonian and French officials envisioned the future of the mobile teams in the independent state.

In this international context, the continuity of the mobile health teams along the French colonial model did not, moreover, proceed without discord and adaptation. The failure of malaria eradication prompted new negotiations between Cameroonian, French and WHO health officials about the proper role of mobile health teams in rural public health. In the 1960s, the WHO began to propose a new conceptualization of rural health that diminished the role of the mobile health teams, and French mobile health service doctors pushed back against these developments even as Cameroonian health officials embraced them. Chapter 5 will more closely examine these debates and their implication for public health administration in the late 1960s.

In the early 1960s, health officials in Cameroon also faced questions unique among former French colonies as they designed national health policy and the place of mobile health teams within it. In 1961, the former French Cameroon unified with part of the territory of the British Cameroons to create the Federal Republic of Cameroon, an officially bilingual French-English state. The territory formerly administered by the French became the state of East Cameroon and a smaller territory formerly administered by the British that became the state of West Cameroon.<sup>216</sup> Throughout the 1960s, Cameroonian health officials negotiated how to

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<sup>216</sup> Cameroon was first a German protectorate from 1884 to 1916. The territory was divided after WWI and made into League of Nations Mandates under British and French administration. With the end of the League of Nations and of WWII, the Cameroons became 'Trust territories' of the United Nations, still under British and French administration. The entirety of the British Cameroons United Nations Trusteeship included a Northern and a Southern Territory on the western border of French Cameroon, and the British essentially administered the territories as part of Nigeria. The French-administered territory of Cameroon became independent on January 1, 1960. In a February 1961 UN-run plebiscite, people living in each of the British Cameroons voted separately on whether to become independent by joining with either Nigeria or the newly independent *République du Cameroun* to the east. The British Northern Cameroons voted to become part of Nigeria and the Southern Cameroons voted to join with the *République du Cameroun*. Delegates from the two territories of the new Cameroon met at the

standardize a national health system from these two colonial medical infrastructures. Within the Ministry of Health, for example, a deputy Minister from West Cameroon served alongside Tchoungui. The Ministry also included two Directors of Public Health, one responsible for East Cameroon and the other for West Cameroon.<sup>217</sup> Over the course of the 1960s, institutions and systems created under French colonial administration came to dominate the national medical system, as was the case in all areas of governance. The larger population and territory of the former French Cameroon as well as the heavy-handed ongoing involvement of the French in the country all contributed to this outcome. As Chapter 3 will show, debates over the extension of the mobile health teams to anglophone West Cameroon became emblematic of this broader national process.

Thus, while the French-Cameroonian relationship profoundly shaped the development of the mobile health teams after 1960, I claim in the following chapters that the negotiation of their place in independent Cameroon was also constituted along other key and intersecting axes—between Cameroonian health officials, with international health organizations, and also with neighboring African states. The subsequent chapters examine how Cameroonians formulated the future of the mobile health team model through each of these relationships and through the messy overlaps of these relationships. This perspective does not de-center the French-Cameroonian relationship in the development of the mobile teams after independence as much

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Foumban conference of July 1961 to create a constitution and framework for the state. The resulting system for the Federal Republic of Cameroon created two states: West Cameroon, the former British Southern Cameroons, and East Cameroon, the former French territory. The Federal Republic of Cameroon came into being on October 1, 1961 and comprised the territorial boundaries of Cameroon that are still in existence today. The federal system was ultimately abolished in 1972 and a unitary national government created. Chapter 3 explains these developments in fuller detail.

<sup>217</sup> SHD ZK 2013 005 406, « Enquête sur la Coopération Technique en Matière Sanitaire au Congo, Gabon, Centrafrique, Cameroun et Tchad, » 4 octobre-6 novembre 1961, Médecin Colonel Diagne

as it insists upon an expansive, international context for its negotiation. Together these chapters ultimately show that through these debates over the future of the mobile teams, Cameroonian health officials forged an international politics of health that reflected at once the enduring impact of empire as well as a new postcolonial politics.

This chapter focuses on how health officials used the mobile health team model to forge new forms of regional health coordination in the 1960s. I show how Cameroonian, Central African and French health officials used the mobile health teams to leverage the post-war language of ‘borderless’ international public health approaches in formulating both a vision and an institutional structure for international public health coordination after independence. Facing the simultaneous changes of decolonization and the growing influence of international health institutions, Cameroonian and French medical officials worked to preserve the mobile health team system, coordinate this system through a regional health organization of former French territories and, in turn, to assert this organization as a key player in international health work.

This regional organization grew out of broader discussions that began in the 1950s between French and African doctors about the future of inter-territorial health coordination, after African territories in the French empire became more autonomously administered from one another with the implementation of the *loi-cadre* after 1956 and then with independence after 1960. French military doctors expressed particular concern for maintaining structures for coordination of mobile health teams across territories that had existed under colonial administration. Although Cameroon had a separate administration due to its status as a United Nations Trusteeship, the federations of French West Africa (AOF) and French Equatorial Africa (AEF) had centralized administration of the mobile teams and thus had institutionalized the possibility for coordination of work across individual colonial territories. Discussions in the

1950s focused on the kinds of health institutions that could be created in the midst of a changing political geography, with those involved seeking not so much to intervene in the form of broader political change that was occurring, but rather to salvage a sense of control over how these changes would play out in the realm of public health. They employed similar language to those involved more directly in the broader political debates, repeating, for example, fears about the ‘balkanisation’ of Africa, while at the same time stressing the particular urgency of countering these developments given the demands of public health work.

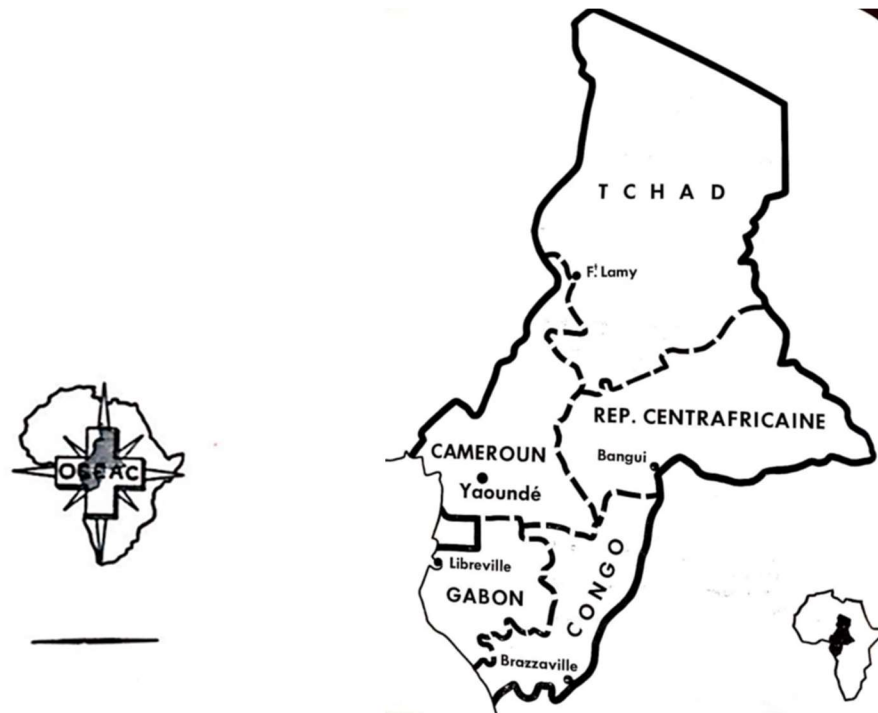
In the wake of the formation of independent African states in the early 1960s and a view of this political geography as a potential threat to public health coordination, African and French public health officials created two new regional health institutions. In 1960, a meeting in Ivory Coast of health ministers of former French West Africa created the *Organization for Coordination and Cooperation in the Fight against Major Endemic Diseases* (OCCGE).<sup>218</sup> All former territories of French West Africa with the exception of Guinea became member states, with France also included as a member.<sup>219</sup> The four former states of French Equatorial Africa (Chad, Central African Republic, the Republic of Congo and Gabon) plus Cameroon formed a parallel organization, OCEAC, the *Organization for Coordination in the Fight against Endemic Diseases in Central Africa*, in 1963.<sup>220</sup>

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<sup>218</sup> French name: *Organisation de coordination et de coopération pour la lutte contre les grandes endémies*

<sup>219</sup>Original members were Ivory Coast, Dahomey, Haute-Volta, Mali, Mauritania, Senegal, Niger plus France. Togo would join the organization later in 1964. Jean-Henri Ricossé and Jean-Alain Husser, “Bilan et avenir de la lutte contre les grandes endémies en Afrique occidentale francophone, » *Cahiers d’études africaines* 22 no. 85-86. (1982) : 147.

<sup>220</sup> The organization originally adopted the acronym « OCCGEAC, » standing for « Organisation de Coordination et de Coopération pour la lutte contre les Grandes Endémies en Afrique Centrale. » By 1965, it shortened the name to « OCEAC » : Organisation de Coordination pour la lutte contre les Endémies en Afrique Centrale. OCEAC still exists in Yaoundé, although its goals have changed.



OCEAC Brochure excerpts. SHD 2013 ZK 005 614, *L'Organisation de Coordination pour la Lutte contre les Endémies en Afrique Centrale*, Plaquette réalisé et éditée par le Secrétariat Général de l'OCEAC à l'occasion de la première Conférence Technique, OCCGE-OCEAC (Paris 2-6 mai 1972)

With headquarters in Yaoundé, Cameroon, OCEAC sought to coordinate the work of its members' national mobile health team services, to compile and share epidemiological information, undertake research, and provide training for medical personnel. In his speech opening the 1963 conference that created the organization, the Minister of Public Health of Cameroon, Dr. Simon-Pierre Tchoungui, emphasized the particular importance of cooperation in the realm of public health in which, "all isolated effort is irreparably doomed to failure."<sup>221</sup> This language of the danger of isolation reproduced a common public health trope that disease knows no borders. Yet, the form of regional health cooperation that became institutionalized through this 1963 meeting upheld a very particular vision of borderlessness, shaped less clearly

<sup>221</sup> My translations. *Rapport Final de la Conférence des Ministres de la Santé des États Équatoriaux*. Yaoundé, les 21, 22, 23 août 1963. World Health Organization Library, Geneva, Switzerland.

by purely apolitical epidemiological concerns than it was by a concern for shaping international health work after independence through the strengthening of ties across francophone African states and the safeguarding of the influential role of France in this realm. More concretely, OCEAC carved out a role for ongoing technical assistance and leadership from France and through French military doctors at a regional scale.

The institutional vision of health coordination represented by OCEAC thus depended on shared leadership between African and French health officials. Both OCEAC and its West African counterpart were inaugurated through elections of an African health minister as their Presidents and with French military doctors with long medical careers in the colonies as their Secretaries-General. Dr. Jean-Claude Happi, the Commissioner General of Public Health for Cameroon, served as OCEAC's first President in 1965 and French Dr. René Labusquière as its first Secretary-General. Guillaume Lachenal's work on decolonization and medicine in Cameroon helps to explain the willingness of African doctors and other public health officials to work so closely with French doctors after independence and to allow them major leadership roles in medical institutions such the Pasteur Institute in Cameroon and in OCEAC. Lachenal has convincingly shown how a sense of a shared medical culture, professional order, and ties of 'familiarity' between Cameroonian and French medical elite shaped the world of medicine and scientific research after political independence in Cameroon.<sup>222</sup> Indeed, the powerful idea of a shared Franco-African medical tradition and culture drove OCEAC's creation, existence, and its functioning.

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<sup>222</sup> For a micro-history of the intimate ties maintained between French and African doctors after independence, see: Guillaume Lachenal. "Franco-African Familiarities. A history of the Pasteur Institute of Cameroun, 1945-2000," in *Hospitals beyond the West: from Western Medicine to Global Medicine*, edited by Mark Harrison and Belinda White (Orient-Longman: New Dehli, 2009), 411-444.

I assert, however, that understanding OCEAC's creation also requires attention to how French and African officials forged this professional world after independence through a very particular geographic vision. Through OCEAC, French, Cameroonian and Central African health officials made a claim on how international public health problems should be framed. They claimed that the member countries shared public health problems and would in turn share approaches to combatting disease. They asserted that OCEAC member states constituted a coherent health region and that external actors should approach it as such. These health officials thus undertook a project of 'region-making' in the realm of health that would subsequently lead to the articulation of health problems and possible solutions through the framework of this region.<sup>223</sup>

I argue that the assertion of OCEAC as a health region grew out of multiple influences: the desire of French doctors to maintain influence through the regional scale of colonial medical governance after independence, the desire of Central African officials to garner political and technical strength through regional integration, and the desire of both groups to create a regional health body different than that of the World Health Organization Regional Office for Africa.<sup>224</sup>

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<sup>223</sup> The idea of 'region-making' in this context builds on other scholarship that has similarly pointed to the constructed nature of borders or scales of representation in medical and public health work. For example, see Nadav Davidovitch and Rakefet Zalashik, "Medical Borders: Historical, Political and Cultural Analyses," *Science in Context* 19. 3 (2006): 309-316. Nicolas B. King, "The Scale Politics of Emerging Diseases," *Osiris* 19 (2004): 63: King draws on the work of geographers Erik Swyngendouw and Niel Smith, "who argue that scale should not be regarded as an ontologically given geographic territory or a priori unit of analysis. Instead it is the outcome of a historically contingent political process, in which actors construct *scalar narratives* that invoke places and spaces at different geographic scales to explain events, enlist allies and attract attention and funding." King observes that the idea that 'disease knows no borders' is a form of scalar narrative.

<sup>224</sup> This desire to create a counter-geography to the WHO shows a contrast with the process of postcolonial region-making that Sunil Amrith describes in his work, *Decolonizing International Health: India and Southeast Asia, 1930-65*. He describes how the "conception of 'Asia' as an administrative category for the government of life and welfare" became institutionalized through the creation of the WHO regional office for Southeast Asia. New leaders in independent Asia enthusiastically supported the creation of the WHO and the regional office. Amrith, 75-76.



First, through OCEAC, French military doctors pursued a protection but also an expansion of the regional scale of colonial medical governance. As this chapter will show, decolonization spurred fears among French military doctors about the breakdown of the scale of coordination for mobile health teams through AEF. They saw the power of coordination not so much in a sense of medical control over vast territories or in controlling medical borders; that vision of the geographic reach of the mobile teams was always an illusory one. Rather, their conception was rooted in the French conception of ‘la médecine de masse,’ that is medicine on a population and not an individual level. Africans thus were framed as ‘populations’ and ‘collectives,’ rather than as individual patients. The reforms of the Brazzaville conference institutionalized this approach to medicine as a priority through the mobile health teams.<sup>225</sup> The mobile health team service meanwhile developed a distinct professional ethos and culture within the French colonial medical service, and through decolonization French doctors sought to protect their professional networks of coordination across territories. The medical ‘borders’ that French military doctors upheld through OCEAC’s creation were thus based on an approach to rural health rooted in the French mobile health team tradition of medical intervention, and the geographic limits of this imperial tradition.<sup>226</sup> Cameroon was central to the French colonial development of mobile medicine and thus, through this framework of medical borders, was tied to the former states of AEF in highly significant ways.

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<sup>225</sup> On the ‘la médecine de masse’ and postwar colonial reform, see Lachenal (2014), 61-65.

<sup>226</sup> Belgian and British colonial authorities did also institute variations on mobile health teams and adopted similar outlooks of ‘social prophylaxis.’ Guillaume Lachenal “A Genealogy of Treatment as Prevention (TASP): Prevention, Therapy, and the Tensions of Public Health in African History,” in *Global Health in Africa: Historical Perspectives on Disease Control*, ed. Tamara Giles-Vernick and James L.A. Webb, Jr., (Athens, OH: Ohio University Press, 2013): 76-77.

The post-independence forging of regional affiliation between Cameroon and other African states required, however, an investment by African health ministers beyond a simple protection of colonial ties. On one hand, Cameroonian health officials, namely health ministers, Dr. Simon-Pierre Tchoungui and Dr. Jean-Claude Happi, enthusiastically pursued this grouping of Cameroon with the former states of French Equatorial Africa in the realm of health. Both French-trained and closely professionally aligned with French military doctors, they proudly celebrated their work as being part of the Jamot legacy of the French colonial mobile health teams. Yet, while OCEAC officials mobilized the Jamot legacy to present Cameroon's inclusion in the organization as an obvious, non-remarkable choice, the particular historical trajectory of decolonization and independence in Cameroon highlights the ways in which OCEAC cannot be seen as a mere bureaucratic extension of colonial medical systems, but instead must be examined as a historically contingent outcome of the decisions by health officials in the early 1960s. Cameroon's distinct administrative status from AEF due to its status as a League of Nations Mandate and then United Nations Trusteeship represented the most important historical element of this difference. Moreover, Cameroonian health officials faced key questions about public health administration in the officially bilingual Federal Republic. Thus while Dr. Tchoungui and Dr. Happi asserted the country as a key player, and indeed headquarters, for the creation of a French-speaking, French-funded and led type of regional health work after independence, this characterization also depended on a negotiation internal to the country about the significance of the Federal Republic to public health administration.<sup>227</sup> Through OCEAC, Cameroonian and French health thus naturalized the idea

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<sup>227</sup> Chapter 3 discusses the dynamics of this bilingual status for public health administration in Cameroon itself.

of independent Cameroon as a partner in health primarily with neighboring former French colonies through the framework of the French mobile health teams.

Cameroonian and other Central African health ministers also justified the grouping of the states based on arguments about shared disease environments and political stances about African regional integration. Health ministers in OCEAC talked about the organization as growing from the legacy of French colonialism, but in contemporary terms about the ecological, cultural and political links that bound the member states to each other and formed them as a region.<sup>228</sup> It was thus African health officials who legitimized OCEAC through a sense of forward-looking political possibility. Despite the absolutely dominant role of French doctors in OCEAC, Cameroonian and Central African health officials working through OCEAC paradoxically upheld the organization primarily as an example of progressive African regional integration and an avenue for development of their states. Some of them saw the organization most importantly as a resource through which to gain additional technical and material assistance directly from France as well as serving as a channel for aid from other organizations. But they also saw it as a resource to solidify the cooperative connections between their states. It was thus both by evoking a shared history of the colonial mobile health teams as well as through a discourse about post-colonial unity that officials in OCEAC crafted the idea of its member states constituting a distinct health region.

Finally OCEAC's creation demonstrated an attempt by French and Central African health officials to create a health organization that operated at a scale beyond the nation but at a

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<sup>228</sup> Amrith, by contrast, shows that Asian leaders focused “more on the ontological fact of Asia’s poverty,” rather than the disease environment, as a unifying regional factor. They pointed in particular to ‘an extreme inadequacy of existing health services.’ Amrith, 77.

smaller scale than the regional vision of Africa asserted by the WHO. By creating a health region that was at once international while explicitly francophone, they thus staked a claim on the operation of international health in independent Africa. This decision grew out of a longer history of general suspicion among French colonial officials towards WHO involvement in Africa and a specific opposition to the establishment of a Regional Office for Africa.<sup>229</sup> In 1952, the World Health Organization established a Regional Office for Africa in Brazzaville, with the intent for the office to focus on most of the continent, excluding North Africa and part of Eastern Africa.<sup>230</sup> OCEAC officials argued that their organization was a more effective alternative to this framework for regional coordination proposed by the World Health Organization. OCEAC thus intervened in the field of international health by creating a francophone African bloc that could assert itself as a forum for regional coordination, an intermediary between member states and international health institutions. OCEAC's exercised this role as an intermediary during the global Smallpox Eradication Program launched in the mid-1960s (see Chapter 4.) The creation and work of OCEAC thus shows how the colonial mobile health team service became reimagined by African and French officials as something that could claim authority in the realm of international health in the 1960s.

The first part of this chapter will zoom the lens out from Cameroon to examine the development of the colonial mobile health teams in the broader regional context of French Equatorial Africa. I will then examine how the legislative and political changes of the 1950s catalyzed debate about the future of inter-territorial coordination of the mobile health teams.

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<sup>229</sup> Jessica Pearson-Patel, "French Colonialism and the Battle against the WHO Regional Office for Africa," *Hygiea Internationalis* 2016 13 (1): 49-64. Accessed December 12, 2016, doi: 10.3384/hygiea.1403-8668.1613165

<sup>230</sup> Pearson-Patel (2016), 67. The Regional Office would focus on the African continent, excluding Morocco, Algeria, Tunisia, Libya, Egypt, Sudan, Ethiopia and Somalia.

The analysis of the 1950s takes a broad view, looking at how French and African officials discussed possibilities across West and Central Africa. Finally, I look more specifically at the process and consequences of the creation of OCEAC in Cameroon in the 1960s.

### **Mobile Health Teams and Inter-territorial Coordination in 1950s French Africa**

The French colonial mobile health team model first developed in response to a widespread sleeping sickness epidemic, caused by colonial penetration, in French Equatorial Africa in first decades of the 1900s.<sup>231</sup> French military Dr. Eugène Jamot first established the mobile health team model in Oubangui Chari (present-day Central African Republic) in 1917, by designating a set geographic ‘sector,’ and the plan to examine as many people as possible within those boundaries.<sup>232</sup> The Governor General of French Equatorial Africa, Gabriel Angoulvant, first sought to expand this work through the creation of additional medical ‘sectors’, although this expansion would be slow to develop in practice due to limited funds and personnel.<sup>233</sup>

In the following decades, French officials institutionalized the model as a central part of the colonial public health administration across its African colonies. Jamot further expanded his work in French Cameroon in the early 1920s, and a 1926 law established a permanent and distinct sleeping sickness service for Cameroon.<sup>234</sup> Following closely in 1927, the then

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<sup>231</sup> Rita Headrick, *Colonialism, Health and Illness in French Equatorial Africa, 1885-1935*, ed. Daniel R. Headrick (Atlanta: African Studies Association Press, 1994): 67-91; 382.

<sup>232</sup> For a description of these early attempts, see Rita Headrick, *Colonialism, Health and Illness in French Equatorial Africa, 1885-1935*, ed. Daniel R. Headrick (Atlanta: African Studies Association Press, 1994): 348-350. Headrick also attributes the initiative for creating the teams to French Equatorial African Governor General Martial Merlin.

<sup>233</sup> Headrick, 352-357.

<sup>234</sup> Josiane Tantchou, *Épidémie et politique en Afrique: Maladie du sommeil et tuberculose au Cameroun* (Paris : L’Harmattan, 2007).

Governor General of AEF, Raphaël Antonetti, also established a separate sleeping sickness service for the federation, the *Service de prophylaxie de la trypanosomiase* (SPT).<sup>235</sup> The SPT remained both financially and administratively autonomous from the more general colonial health service in French Equatorial Africa, the *Assistance médicale indigène* (AMI), which worked primarily through stationary medical posts in the forms of hospitals and infirmaries. The budget of each individual colony in French Equatorial Africa funded the running of the AMI in its own territory. The SPT, focused on the mobile approach to sleeping sickness, gained funding through the federation's general budget, with support from France in the form of subsidies.<sup>236</sup> As a League of Nations mandate under French administration during this period, Cameroon's health service, including the sleeping sickness service, had a distinct territorial administrative structure from the neighboring colonies of French Equatorial Africa.

In the 1930s, French officials also implemented this model in French West Africa, with Jamot based in the area between 1931-1935. In 1939, Médecin-Colonel Gaston Muraz, who had previously led the sleeping sickness service in AEF, became head of the newly institutionalized *Service général autonome de la maladie du sommeil* (SGAMS) for French West Africa and Togo with the head of the service in Bobo-Dioulasso.<sup>237</sup> These teams across the French empire in Africa focused exclusively on sleeping sickness at first, but they also established a new philosophy and model for French colonial medical administration. This model would endure, even as it was modified, in the years ahead.

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<sup>235</sup> Headrick, 367.

<sup>236</sup> Headrick, 197.

<sup>237</sup> Ricossé and Husser, 146.

The Brazzaville Conference in 1944 put forward recommendations to make the sleeping sickness service into a multi-purpose one.<sup>238</sup> The service would continue to deal with sleeping sickness but would also take on the task of confronting other endemic diseases, such as malaria, tuberculosis and leprosy. The service previously known by the acronym of SGAMS became the SGHMP, *le Service Général d'Hygiène Mobile et de Prophylaxie*.<sup>239</sup> Both French West Africa and French Equatorial Africa had their own SGHMP centralized at the level of each federation. Despite its special administrative status similar to that of Cameroon, the legislation called for the mobile service of French West Africa to be extended to Togo. Cameroon, on the other hand, created its own distinct service from the start; it was not administratively tied to the neighboring federation of French Equatorial Africa.<sup>240</sup> The headquarters for the West African service was based in Bobo-Dioulasso and in Brazzaville for French Equatorial Africa. The new legislation maintained the structure of having the budget for the mobile service at the federation level in the general budget.<sup>241</sup> The service divided the given territory of coverage (both the federations and Cameroon) into 'sectors' and strove to cover each of these units with teams that could regularly travel to rural areas to examine people for disease, perform vaccinations and in some cases pursue treatment of disease. The postwar French program for development in the

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<sup>238</sup> Ricossé and Husser, 146.

<sup>239</sup> Pierre Richet, « La lutte contre les grandes endémies tropicales en Afrique noire francophone' *Afrique Contemporaine* Nov-Dec. (1980) : 3.

<sup>240</sup> SHD 115, 5 June 1944, Le Commissaire aux Colonies à Monsieur le Gouverneur Général de l'Afrique Occidentale Française, Monsieur le Gouverneur Général de l'Afrique Equatoriale Française, Monsieur le Gouverneur du Cameroun, Objet: Organisation des Services Généraux d'Hygiène Mobile et de Prophylaxie. ; June 15 1944 'Décret relatif à la création d'un service général d'hygiène mobile et de prophylaxie en Afrique Occidentale Française et au Cameroun. » Tantchou, 93 : decree of June 15, 1944 creating the SGHMP went into effect in French West Africa on January 1, 1945, in French Equatorial Africa on October 24, 1945 and in Cameroon on April 15, 1947.

<sup>241</sup> SHD 115, June 1944 Décret

colonies, FIDES (*Fonds d'Investissement Economique et Social*), contributed to the growth of the teams through funding for equipment, infrastructure and supplies.<sup>242</sup>

The full realization of the plans for the SHMP was, however, slow, to develop and uneven across territories. In 1945, colonial authorities in AEF designated 19 principal and 7 secondary sectors for the work of the mobile health teams with the intent to have at least one mobile team operating for each sector. Due to a lack of medical staff and equipment, each sector did not have an operational team until 1957.<sup>243</sup> Despite further investment in health after World War II, the colonial service in AEF operated throughout the postwar period with relatively few medical personnel. In 1952, the SHMP worked with a staff of only 277 for the entire federation.<sup>244</sup> Cameroon, a privileged site of French investment due to its status as a Trusteeship, reported in 1951 the use of 203 medical personnel in the SHMP for the single territory.<sup>245</sup>

At the same time, although the mobile teams were much-celebrated by the French military doctors running them, the teams were not without their critics within the colonial administration. Before the reforms of the Brazzaville conference, some criticized the singular

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<sup>242</sup> Lachenal (2014), 59.

<sup>243</sup> Virginia Thompson and Richard Adloff, *The Emerging States of French Equatorial Africa* (Stanford: Stanford University Press, 1960), 333.

<sup>244</sup> William Hailey, *An African Survey: A Study of Problems Arising in Africa South of the Sahara*, Revised 1956 (London: Oxford University Press, 1957), 1090. The broader colonial medical staff for AEF in 1952 comprised of European staff: 119 registered physicians and 189 nurses. 108 sanitary inspectors included both European and African personnel. The African personnel was comprised of 41 physicians ("médecins Africains trained in Dakar) and 3 public health assistants. The number of African nurses or auxiliary personnel is not reported.

<sup>245</sup> 30 of these personnel were European and 173 Cameroonian. An additional 1165 staff worked in the general Cameroonian medical service (AMI). SHD 2013 ZK 005 100, *Cameroun Français, Service de Santé, Année 1951, Rapport Annuel*, Médecin-Colonel Vaisseau, Directeur du Service de la Santé Publique.



focus of resources and personnel on sleeping sickness.<sup>246</sup> Legislation in the early 1930s had attempted to integrate the sleeping sickness service with the AMI in both French Equatorial and French West Africa, but this direction was abandoned before the decade ended.<sup>247</sup> But after the expansion of the service to focus on various ‘grandes endémies,’ such as leprosy and malaria, critiques from both within and outside of the French colonial health service continued, often focused on the autonomy of the mobile service from the rest of the colonial health structure. Debates between colonial medical officials continued through the early 1950s about the most desirable structure for the mobile service, and some continued to raise questions about the optimal balance between ‘fixed’ and mobile medicine, between curative and preventive medicine, and about the autonomy of the mobile service, which grew in part from its centralized, federation-level structure.

A 1952 Conference of Directors of Public Health in French Africa brought these debates to the foreground. Dr. Louis-Paul Aujoulat, Secretary of State for Overseas France, presided over the meeting and opened a session of the conference on July 29th devoted to a discussion of the mobile service across the French territories in Africa. He noted that a memo he had sent out early that year had raised concern from medical officials that he wished to eliminate the mobile service, but he assured the assembled group that his concern was really to find a better structure between the mobile service and the territorial health services.<sup>248</sup> He spoke about the need for

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<sup>246</sup> Headrick, 370.

<sup>247</sup> On legislation in AOF : SHD 115, 26 Oct 1954 ‘Note sur le Service Général d’Hygiène et de Prophylaxie de l’A.O.F. : Raisons pour lesquelles la déconcentration ne doit pas s’appliquer à ce service. » Le Médecin Général Inspecteur Robert, Directeur du Service de Santé de la France d’Outre-Mer. » On AEF see Headrick, 208.

<sup>248</sup> SHD 2013 ZK 005 79, « Réunion des Directeurs de la Santé Publique en Afrique, 28 Juillet-3 Août 1952, Séance du Mardi 29 Juillet (matin), » 6.

better coordination and communication between the two distinct health service branches.

Aujoulat also addressed the question of centralization:

Another aspect of the problem is this: in certain federations, and I am thinking here mainly of AEF, the tendency has been, on several occasions to dismantle the *service général d'hygiène mobile et de prophylaxie* to reestablish it in parts in each of the territories. I don't have to tell you that in this regard the position of the Department has always been unequivocal. We reckon that as long as the governments general exist the *service général d'hygiène mobile et de prophylaxie* must have an existence within the framework of the federation and it must be supplied, of course, by the federal budget.<sup>249</sup>

Colonel Lotte, Director of the SGHMP for AEF, continued on this point, warning of the “imminent peril” facing the SGHMP in AEF from a budgetary standpoint, and from the possibility of “territorial vivisection.” He argued that the budget of the SGHMP had remained unchanged since 1948, all while the number of sectors for their work had increased from nine to thirteen. Meanwhile, the government of AEF “had established a project of budgetary decentralization of the SGHMP, that is to say that the general budget would furnish a subsidy to the territories and the territories would have entire responsibility for the administration and functioning of their mobile service.”<sup>250</sup> He warned of this set up leading to a situation in which the federal government would become detached from local work and local authorities would have the excuse of not receiving adequate funds. Ultimately, he argued, this arrangement would be completely at odds with the letter and the spirit of the decree of 1944 that established the

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<sup>249</sup>SHD 2013 ZK 005 79 « Réunion des Directeurs de la Sante Publique en Afrique, 28 Juillet-3 Août 1952, Séance du Mardi 29 Juillet (matin), » 8.

<sup>250</sup>SHD 2013 ZK 005 79 « Réunion des Directeurs de la Sante Publique en Afrique, 28 Juillet-3 Août 1952, Séance du Mardi 29 Juillet (matin), » 28-29.

AEF service.<sup>251</sup> Dr. Aujoulat responded that it was “absolutely not possible to let the SGHMP be dismantled or to accept a territorial separation” and that explanations would be required from the High Commissioner of AEF.<sup>252</sup>

As the attendees continued to discuss a desirable coordination between the SGHMP and the general health service, the AMA<sup>253</sup>, Médecin-Colonel Vaisseau, highlighted his experience as Director of Public Health for Cameroon. When it came to the relationship between the two branches of the health service, Vaisseau observed that Cameroon was lucky, “even enormously lucky” to be a territory “one and indivisible.” Referring to Cameroon’s special status as a United Nations Trusteeship under French administration, which required that its administration remain separate from the federations, Vaisseau concluded that “the problems of communication, of collaboration between the fixed and the mobile are infinitely less delicate to resolve than in a federation.”<sup>254</sup> He compared this to his five years of service in French West Africa where he saw and prepared memo after memo about the need for collaboration and communication, but then saw that this hope largely stayed on paper.

Vaisseau argued that safe-guarding both the distinctness of the mobile medicine model and its budgetary autonomy were absolutely necessary, but that at the same time public health in

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<sup>251</sup> Lotte explained that the AEF government officials were arguing that the 1947 law giving the ‘Grand Conseil’ of the federation the right to decide on ‘les modalités d’exploitation et de fonctionnement des services du budget général’ allowed for decisions over how the SGHMP budget would work.

<sup>252</sup> SHD 2013 ZK 005 79 « Réunion des Directeurs de la Sante Publique en Afrique, 28 Juillet-3 Août 1952, Séance du Mardi 29 Juillet (matin), » 33.

<sup>253</sup> Note : the AMI (Assistance Médicale Indigène) was renamed the AMA (Assistance Médicale Autochtone) after World War II, but attendees of this conference slipped interchangeably between the two names in referring to the service, undoubtedly because many of them had worked in the health service under the name of AMI.

<sup>254</sup> SHD 2013 ZK 005 79 « Réunion des Directeurs de la Sante Publique en Afrique, 28 Juillet-3 Août 1952, Séance du Mardi 29 Juillet (matin), » 56-57.

any given territory should not be seen as bifurcated between the two services. He offered that Cameroon could serve as an example of the relationship between the fixed and mobile service, an example that could then be applied to a federation.<sup>255</sup> Colonel Sanner of AOF pushed back, saying that “the solutions offered to us by our colleagues from the autonomous and mandate territories did not provide a solution to the problem, and they propose a solution that leads to the breaking up of the SGHMP.”<sup>256</sup> This meeting did not reach consensus on how to best resolve these ongoing issues, but it did affirm the necessity of maintaining the intended centralization of the SGHMP by federation.

Despite this ultimate affirmation of the SGHMP structure in 1952, the practical questions surrounding the parameters of the service continued to provoke debate in the years that followed. In 1954, the Federal Director for the SGHMP of French Equatorial Africa, Dr. Pierre Richet, wrote a pointed memo about the budgetary difficulties facing his service in the wake of a refusal by the *Grand Conseil* of the federation to accord certain requested aid. Richet responded to critics who saw it as a well-endowed service that had misused and wasted its resources, countering that the service didn’t have enough money for sectors’ necessities such as

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<sup>255</sup> Vaisseu explained that in Cameroon the head of the mobile service served as a close and important collaborator with the Director of Health, like a deputy director. Cameroon was divided into regions for the purpose of public health administration, like all of the territories. Each region would have a fixed and mobile component, with one taking precedence over the other in some regions, depending on the specific health concerns. The implication of this is that the doctor in charge of either service in a given region would be in charge medically for the region. In turn, the mobile groups in any region would be focused on the particular diseases of importance to that region. Vaisseu argued that a federation such as French West Africa could effectively be thought of as ‘five, six or seven Cameroons’ with a local director of health in each territory working closely with a local director responsible for the mobile service. The debate that ensued revolved around the question of the leadership of the mobile service in relation to the Directors of Health of individual territories as well as the Director General of health for the federation. For example, attendees discussed whether making the director of the mobile service more closely tied to the Director General of Health for a federation would overburden his responsibilities. In French West Africa this issue took on an additional dimension, because the mobile health service was headquartered in a different city, Bobo-Dioulasso, than the federal government based in Dakar.

<sup>256</sup> SHD 2013 ZK 005 79, 61-62.

the repair of broken down vehicles. Twelve new sectors projected to be established in 1945 had never been created. Richet argued that the current budget further prevented the purchasing of necessary medications and supplied.<sup>257</sup> He pleaded that the SGHMP of French Equatorial Africa not be left to “die little by little” and referred to the affirmation of the service’s work, its financial autonomy, and its federal administration made in the 1952 Conference of the Directors of Health.

Similarly, speaking to ongoing suggestions in 1954 to decentralize the service in French West Africa, Dr. Robert, the *Directeur du Service de Santé de la France d’Outre-Mer*, also pushed back against the idea, pointing to the earlier attempts in the 1930s to combine the mobile service with the general health service and characterizing them as a mistake. He emphasized that the “prophylactic, mobile and rural” action of the service was only possible for a service granted, “budgetary, administrative and technical autonomy, a central management, freedom from administrative borders, and a specialization of personnel.”<sup>258</sup> Speaking specifically to a need to work across ‘administrative borders,’ Robert argued that action against disease would crumple in the face of a focus on ‘local interests’ and that responding to more general concerns must be the goal of public health. He continued to say that the SGHMP of West Africa was a model that was starting to be replicated by other governments in Africa, and notably that it had gained the admiration of representatives from international organizations, a group he noted to be

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<sup>257</sup> SHD 101, Brazzaville, le 29 Juin 1954, ‘Fiche sur les Actuelles Difficultés Budgétaires du SGHMP d’AEF,’ No. 39 bis/HP.T., Le Médecin-Colonel Richet, Directeur Fédéral du S.G.H.M.P, Inspecteur Général de l’Hygiène et de la Prophylaxie d’AEF.

<sup>258</sup> SHD 115, 25 Oct 1954, Le Médecin Général Inspecteur Robert, Directeur du Service de Santé de la France d’Outre-Mer. *Note sur le Service Général d’Hygiène et de Prophylaxie de l’AOF. Raisons pour lesquelles la déconcentration ne doit pas s’appliquer à ce service.*

otherwise quite ‘stingy’ with compliments. Finally, he argued that ‘the federal conception’ of the mobile service:

..is consistent with the evolution of world politics in the domain of health; the creation of international or intergovernmental organizations: the WHO, UNICEF, CCTA, is dictated by the more and more clear necessity of a coordinated action against disease; medical cooperation between countries is the order of the day, particularly in Africa. (Accra Conference in 1946, Dakar in 1951, Léopoldville planned for 1955).

It is at this exact moment when this development asserts itself that we are going to, with our own hands, dismantle a particularly effective national organization, which the Conference of Directors of Public Health, presided over by Doctor Aujoulat, Secretary of State of Overseas France, reaffirmed in 1952, judging from the technical point of view, the necessity of avoiding its ‘break-up.’

It’s at the moment where the coordination and the medical cooperation between countries proves to be more and more necessary that we are going to destroy in large part the possibilities of medical cooperation between our own territories.....

Decentralization in the area of the SGHMP of AOF would be a step back of thirty years as much from the point of view of the protection of health of the populations concerned as from the world evolution of the conception of this protection.<sup>259</sup>

Robert thus characterized the inter-territorial nature of the mobile health service, in its federal structure, as something that was progressive and in line with developments in international health. More importantly, this was a *French* model of such developments, which facilitated claims by French colonial medical officials about the strength of their work in African territories. These comments spoke to a broader anxiety among French colonial medical officials

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<sup>259</sup> SHD 115, 25 Oct 1954, Le Médecin Général Inspecteur Robert, Directeur du Service de Santé de la France d’Outre-Mer. *Note sur le Service Général d’Hygiène et de Prophylaxie de l’AOF. Raisons pour lesquelles la déconcentration ne doit pas s’appliquer à ce service.* The CCTA (Combined Commission for Technical Cooperation in Africa South of the Sahara) was an inter-colonial body established by the French and Belgian governments in 1950. The organization later included the British, Portuguese, and South African governments. Liberia became the only independent African governmental member. James Gillespie argues that the CCTA sought to be an intermediary for WHO and other UN agency programs in Africa, and ultimately limit their intervention. The agency lacked funds and eventually political will, however, and did not succeed in its intended role. James A. Gillespie, “Europe, America, and the Space of International Health,” in *Shifting Boundaries of Public Health: Europe in the Twentieth Century*, ed. Susan G. Solomon, Lion Murard, and Patrick Zylberman (Rochester, NY: University of Rochester Press, 2008): 130-131

at this time about the growing role of international health organizations in Africa and the desire to maintain control and influence over the nature of this role.<sup>260</sup>

Within these conversations about the need to maintain the autonomy and inter-territorial nature of the mobile teams, Cameroon continued to represent an outlier through its administrative distinctness and status as a United Nations Trusteeship. From the inception of the teams in the interwar period, when Cameroon was classified as a League of Nations Mandate, this administrative distinctness had ramifications for the functioning of the mobile health service. In the early 1930s, for example, mobile Sector 11 in Chad, based between Fort-Lamy and Lake Chad did not coordinate at all with teams across the border in Cameroon and their work proved to be particularly inept and disorganized. People living in Chad in turn leveraged this political and medical border to their own ends, crossing the border into Cameroon to avoid medical examination.<sup>261</sup>

Any subsequent efforts at medical coordination could not bypass the political and bureaucratic divide between Cameroon and the neighboring territories belonging to the federation. In 1951, the head of the SHMP in Cameroon, Médecin-Colonel Beaudiment, corresponded with the head of the mobile team in Fort Fourreau, Cameroon, about a proposal to coordinate with medical officials across the border in Chad on a canvassing of the area for cases of sleeping sickness and potentially a joint effort to proceed with injections of lomidine, the drug being used at this time in both curative and protective capacities against the disease.<sup>262</sup>

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<sup>260</sup> Jessica Pearson-Patel, *From the Civilizing Mission to International Development: France, the United Nations, and the Politics of Family Health in Postwar Africa, 1940-1960* (Dissertation, New York University, 2013).

<sup>261</sup> Headrick, 369.

<sup>262</sup> On the history and controversy surrounding the use of this drug in Africa : Guillaume Lachenal, *Le Médicament qui devait sauver l'Afrique: Un scandale pharmaceutique aux colonies* (Paris : La Découverte, 2014).

Beaudiment reminded the mobile team head that such coordination, particularly the idea of an actual entrance of the Cameroonian team into Chadian territory, was not just a medical question and must be fully approved by administrative authorities of Chad.<sup>263</sup> At the same time that French colonial officials upheld the administrative significance of this border, they also recognized the fluidity of people across it, to a degree that they often felt helpless to control.<sup>264</sup> The ‘medical border’ between AEF and Cameroon was thus politically or administratively constituted in ways often at odds with how people actually lived and moved in the space, but this border did create practical realities for the implementation of health campaigns. Throughout the postwar period, colonial officials framed the challenges of rural health through the mobility of the health service itself, rather than through the mobility of people.<sup>265</sup>

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<sup>263</sup> NAC 3AC 1116, 18 Août 1951, Le Médecin Colonel Beaudiment, Chef du Service d’Hygiène Mobile et de Prophylaxie du Cameroun à Monsieur le Chef du Groupe Mobile no. 8.

<sup>264</sup> NAC 2AC 6314, “Correspondance de 1954 relative au transfuge de l’A.E.F. dans les differents (sic) régions du Nord-Cameroun, 1954.”

<sup>265</sup> The mobility of populations within and across borders in AEF and French Cameroon varied in its nature across territories. The directions of this mobility were shaped all at once by economies rooted in deeper local histories, the changes brought by colonialism, and African responses to these changes. Historic ties of religion, language, and trade rooted in Fulani conquest in the 19<sup>th</sup> century, for example, created an important axis of east-west movement between northern Cameroon and northern Nigeria (partially comprised by British Cameroon), which will be discussed further in chapter 4. For the following references, Virginia Thompson and Richard Adloff, *The Emerging States of French Equatorial Africa* (Stanford, California: Stanford University Press, 1960). Movement across this area also went into Chad, gaining particular volume during the annual pilgrimage to Mecca. (93) A common reaction to highly mobile populations within territories by the French colonial government was to forcibly attempt to settle them, as was attempted in northern Cameroon and noted in the previous chapter. The French attempted the same with the Fang of Gabon in the first decades of the 1900s, where people emigrated towards active trading zones both within the territory and across the border to Cameroon and Equatorial Guinea (347) Much of the migration of people across the territories of AEF and Cameroon after WWII resulted from labor recruitment and movement of people to towns for wage labor. Within AEF, this was a general southward push, with Chadians going to Oubangui-Chari and Oubanguians moving to Gabon and Moyen Congo (259). The forest industry in Gabon, for example, recruited people from the northern areas of AEF as well as from Nigeria to the territory (259,381). People in AEF also had regular contact across the border with Belgian Congo. People in Oubangui-Chari conducted trade along the 1,200 kilometers of river marking the border with Belgian Congo (385). People also circulated intensively between the neighboring cities of Brazzaville in Moyen-Congo and Léopoldville in Belgian Congo. Another form of important mobility was that of people trying to escape forced labor in the earlier colonial period and taxation. Just as people sometimes used borders to escape vaccination, they also used borders to escape taxes on both their person and their goods, such as people in nomadic populations in Chad who crossed their livestock into Nigeria to avoid taxation (445).



This border illustrates one of the many gaps between the rhetoric of the reach of mobile health teams and their practical implementation. This often large gap between what colonial medical officials set out to do and the success or even possibility of acting on these plans when confronted with the choices of individuals and groups targeted for intervention, or with their own professional shortcomings, certainly constitute a central part of the history of the mobile teams, as they do more broadly in many histories of colonialism and medicine. And during this time in the early 1950s, the French mobile teams were often very far from living up to the ideal of their mission given the many histories of resistance or indifference to their work in communities, inefficiency due to lack of funds, equipment and personnel, and in some cases, outright medical disaster.<sup>266</sup>

Meanwhile, the ideal of a structure of federation-wide mobile services pursuing polyvalent work remained contested and unstable. Even before the political changes of the late 1950s that would raise increasing alarm about the fate of the mobile teams, a constant discourse of threat and of potential breakdown ran through conversations about the health services. When French doctors began in the 1950s, therefore, to lament the possible breakdown of the inter-territorial coordination of mobile health teams, they were lamenting something that was in fact relatively new and certainly far from fully realized in its specific formulation.

That said, during the period between the reformulation of the teams through the Brazzaville conference in 1944 and the *loi-cadre* in 1956, French medical officials created a geographic vision of the mobile services that would serve as an enduring and powerful reference point even as African medical officials eventually took positions of authority within

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<sup>266</sup> Lachenal, 2014.

their territories. At the heart of this geographic vision was the idea that a certain kind of medicine must not be contained by stationary medical posts or by politically-invested borders. As shown, some upheld this model as a French version of postwar trends towards geographically vast and coordinated approaches to disease as represented by international organizations. In this way, proponents of the teams were able to argue that their interests extended beyond the ‘local,’ to a more powerful, more modern vision of the possibilities for medicine. The idea of a legacy of the mobile teams to protect—one that was conceptually shaped by a philosophy of medicine as well as a geographic framework--became a powerful one among African and French medical officials. This idea drove reactions of health officials to political changes in the late 1950s, and ultimately to the creation of regional health organizations in the 1960s.

### **Health Services and the Loi-Cadre**

The broader political changes to colonial administration in Africa in the mid-late 1950s forced fundamental questions about the future of the mobile health services. The 1956 *loi-cadre*, or ‘framework law,’ which moved legislative and administrative authority away from the federation-level Government-General of French West Africa and French Equatorial Africa towards elected territorial assemblies, brought significant changes for the structure of mobile health teams. The law placed greater responsibility for the budgets of individual African territories in the hands of locally elected officials, thus deflecting to them the burden of responding to the mounting claims of African citizens for greater equality between metropole and colony in areas such as civil service salaries.<sup>267</sup> People in each territory would from this point

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<sup>267</sup> Frederick Cooper, *Decolonization and African Society: the Labor Question in French and British Africa* (Cambridge: Cambridge University Press, 1996).

forward vote by universal suffrage on a territorial assembly, which would have ministerial powers. The law also specifically created two spheres of governmental powers: the ‘Services d’État’ and the ‘Services Territoriaux,’ with the concept that there would be a division between powers exercised centrally through Paris (Services d’État) and those that were exercised at the level of individual African territories. A decree in April 1957 set the actual parameters of this division of power. While the French government maintained authority over areas such as foreign affairs and defense, the individual ‘territorial services’ would have responsibility over most public services.<sup>268</sup> Those services falling under the realm of territorial responsibilities included the health services. The law also turned the African civil service into territorial services.<sup>269</sup> The decree characterized those responsibilities maintained by the French government as those considered necessary for ‘maintaining the solidarity of the elements comprising the Republic.’<sup>270</sup>

Meanwhile, the law significantly emptied power at the federation-level of authority in both French West Africa and French Equatorial Africa, with the Government-General and the *Grand Conseil* having little authority over the territories.<sup>271</sup> Historian Tony Chafer writes that the loi-cadre thus produced “the political and economic ‘balkanization’ of French Black Africa” with political leaders finding themselves “increasingly locked into the logic of a system that attached political primacy to the territory.”<sup>272</sup> Prominent political leaders such as Léopold

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<sup>268</sup> Tony Chafer, *The End of Empire in French West Africa: France’s Successful Decolonization?* (Oxford; New York: Berg, 2002), 166.

<sup>269</sup> Chafer, 167.

<sup>270</sup> Decree dated 4 April 1957, *Journal Officiel. Lois et Décrets (JOLD)*, 13 April 1957, p. 3952 quoted in Chafer, 166.

<sup>271</sup> Chafer, 171.

<sup>272</sup> Chafer, 172.

Senghor, future president of Senegal, had opposed the legislation precisely due to this fear of the ‘balkanization’ of French Africa, or the move towards more autonomy in the form of smaller political and geographic units as opposed to federations.<sup>273</sup> Political leaders in French Equatorial Africa expressed less concern over these changes and were more focused on “maintaining and increasing France’s financial and economic aid to AEF and with the reorganization of the civil service.”<sup>274</sup>

French Cameroon’s political trajectory in relation to that law was somewhat distinct from French West Africa and French Equatorial Africa, given its status as a United Nations Trusteeship.<sup>275</sup> There, for example, the question of federal vs. territorial power did not have relevance. Similar to other territories, however, the law did lead to territorial elections with universal suffrage and a single electoral college, thus investing more political power in elected Cameroonian officials, while continuing to reserve a broad sphere of control for French authorities. One notable change came through a 1957 statute changing Cameroon from a ‘trust territory’ to a ‘trust state’ with nationals categorized as Cameroonian citizens.<sup>276</sup> Within the realm of health, as in other territories, Cameroon would have a Minister of Public Health within its

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<sup>273</sup> On these debates: Frederick Cooper, *Citizenship between Empire and Nation* (Princeton: Princeton University Press, 2014).

<sup>274</sup> Virginia Thompson and Richard Adloff, *The Emerging States of French Equatorial Africa* (Stanford: Stanford University Press, 1960), 35.

<sup>275</sup> The law laid out distinct provisions for Togo and Cameroon, both United Nations Trusteeships and ‘Associated Territories’ of the French Union: Martin Atangana, *The End of French Rule in Cameroon*, Lanham, Maryland: University Press of America, 2010, 36. Cameroon’s political status also raised questions about the legitimacy of applying the loi-cadre there. Anti-colonial nationalists of the political party, the *Union des populations du Cameroun (UPC)* in Cameroon vehemently opposed the application of the loi-cadre there on the basis of this special status. See Meredith Terretta, *Nations of Outlaws, State of Violence: Nationalism, Grassfields Tradition, and State Building in Cameroon* (Athens, Ohio: Ohio University Press, 2014), 100.

<sup>276</sup> Atangana, 38.

government from 1957 forward, but overall structural changes were less pronounced than in the federations.<sup>277</sup>

For the federations of West and Equatorial Africa, the changes to the health services revolved around the newly defined designation of territorial services. First, the *loi-cadre* catalyzed the decisive ‘territorialization’ of the general health service. For the mobile services, some structure of cross-territorial coordination remained. French observers of this change, however, characterized the law as ultimately producing the same fundamental changes for the mobile service: an emptying of federation-level coordination and a cutting up of the service into smaller territorial units. A decree of December 16, 1957 created the *Service Commun de lutte contre les Grandes Endémies* (S.C.L.G.E.) for French West Africa from the former SGHMP.<sup>278</sup> This change downgraded the role of the director of the federal service for French West Africa; the active director, Dr. Pierre Richet, became the ‘adviser’ of the SCLGE for West Africa, with his posting moved from Bobo-Dioulasso to Dakar. The position, while maintaining a level of oversight over the grouping of territories, was ultimately a diminished role.<sup>279</sup> Each territory now also had an individual mobile service, called the *Services territoriaux d’hygiène mobile et de prophylaxie* (STHMP).<sup>280</sup> Decrees in April and November 1957 similarly established the new structure of the service in French Equatorial Africa, going by the less succinct name of the

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<sup>277</sup> *Les Services de la Santé Publique du Cameroun en 1957*, Yaoundé, Juin 1958, Le Ministre d’Etat Chargé de la Santé Publique et de la Population : Njoya Arouna, 3. World Health Organization Library, Geneva, Switzerland.

<sup>278</sup> SHD 2013 ZK 005 101 « Procès-verbal de la Commission consultative du Service de Lutte Contre les Grandes Endémies » Dakar, 7-10 Juillet 1958. »

<sup>279</sup> P. Richet, « L’Histoire et l’Oeuvre de l’O.C.C.G.E. en Afrique Occidentale Francophone, » *Trans R Soc Trop Med Hyg* 59 (1965) : 236. Jean-Paul Bado, « La santé et la politique en AOF et à l’heure des indépendances (1939-1960), » in *AOF : Réalités et héritages : Sociétés ouest-africaines et ordre colonial, 1895-1960. Tome 2*, ed. Charles Becker et al. (Dakar: Direction des Archives Nationales du Sénégal, 1997), 1255.

<sup>280</sup> Bado (1997), 1254.

*Service de la lutte contre les Grandes Endémies du Groupe de Territoires de l'A.E.F.* Similar to French West Africa, the head of the service could provide technical direction, but ultimately the authority over mobile teams moved to the individual territorial level.<sup>281</sup>

Writing in 1958 about these changes, Dr. Louis-Paul Aujoulat noted that the mobile service maintained some structure at the inter-territorial level, he asked, “but for how long, and with what means of action?”<sup>282</sup> He lamented the application of the loi-cadre in the realm of health precisely because of the move away from inter-territorial direction and the potential for ongoing and progressive developments in this direction:

How to actually be assured that the local governments, who are the master hand, will bring to vaccination or screening campaigns the material and administrative support without which they will not reach the masses. Who can guarantee that the territories will always decide to harmonize and synchronize their efforts so that the sanitation undertaken by some is not thwarted by the inertia of others. What good, for example, to attempt to eradicate malaria in Togo if it remains in Dahomey? What good to establish a rampart against trypanosomiasis in Upper Volta by the permanent reduction of contamination if it at the same time is given free reign in Côte d'Ivoire? It is on this plane that a harmonization, which cannot be imposed by law, must be organized and negotiated spontaneously between the territories.

Aujoulat's concerns highlighted the superficiality of politically designated borders in the face of disease spread, but he notably contained these concerns within the borders of French empire. He used the illustrative example of the Togo/Dahomey (present day Benin) border, for example, but not the border between Togo and the newly independent Ghana, or between Dahomey and

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<sup>281</sup> SHD 2013 ZK 005 101, Groupe de Territoires de l'A.E.F., Service de Lutte Contre Les Grandes Endémies, Inspection Générale des Affaires Administratives, No. 387/IGAA., Brazzaville, 7 Février 1958. SHD 2013 ZK 005 101, Inspection Generale des Affaires Administratives, No. 71/IGAA, 'Note sur le Service de Lutte Contre les Grandes Endémies, » Brazzaville, 21 Mars 1958.

<sup>282</sup> Louis-Paul Aujoulat, “Médecine et Santé Publique dans les territoires d'Outre-Mer au lendemain de la Loi-Cadre,” *Concours Médical* 80.14 (1958) : 1729.

Nigeria. Using these two smaller territories, sandwiched between British and former British-controlled territories, as examples in fact highlighted the political parameters of this vision of public health. One might have asked instead, what good to attempt to eradicate malaria in Togo and Dahomey if it still existed in Nigeria? But Aujoulat took up the concept of disease eradication—an inherently global concept—and shrunk it to the scale of French territories. He was specifically focused on the changes to public health administration in the face of the loi-cadre and his public health concerns, while emphasizing ideals of cross-border coordination and ‘harmonization,’ maintained these ideals as something that had and should continue to happen between the French-administered territories of Africa.

Meetings between health officials in both French West Africa and French Equatorial Africa took up these questions of what inter-territorial coordination would entail in the context of this ongoing political change. In July 1958, Ministers of Health of the territories of West Africa met under the title of the *Commission Consultative du Service de lutte contre les Grandes Endémies* in Dakar for four days of meetings.<sup>283</sup> The commission met twice yearly between 1957-1959.<sup>284</sup> The commission grew out of the 1957 legislation creating the *Service Commun*, with the role of meeting to examine the annual programs, campaign plans and budgets of the services identified through this same legislation. The legislation had on one hand created the *Service Commun de lutte contre les grandes endémies*, which included an “executive body and organizations for research, study and the training and specialization of technical personnel” and on the other hand the territorially-bound mobile health teams. By extension, the budgets of

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<sup>283</sup> A representative on behalf of the Minister of Health of Togo, a UN Trusteeship and not part of the grouping of French West Africa (AOF) did attend the meeting in an observational capacity, but was not listed as one of the commission members.

<sup>284</sup> Richet (1965), 236.

the health teams were also “territorialisés.”<sup>285</sup> Dr. Richet, who served as the head of this service, wrote retrospectively in 1965 that these meetings had served to “recreate this coordination that sorely lacked and to remedy its temporary disappearance.”<sup>286</sup>

Attendees of these meetings raised not only the question of how they would interact among themselves going forward, but also how they would interact with international health organizations in light of the new administrative structure. At the request of the representative from Dahomey, a point of discussion for the meeting characterized as a “Study of relations with international organizations” became part of the agenda of the meeting. Minister Eouanignon of Dahomey raised the question of what these ongoing changes to health administration meant for interaction with organizations such as the specialized United Nations bodies of the World Health Organization and UNICEF. He asked, should the territories interact directly with these organizations, or should they pass through the *Conseiller à la lutte contre les Grandes Endémies*, Dr. Pierre Richet.<sup>287</sup> This point raised essential questions about the extent of newly designated territorial autonomy; how and when would this autonomy be recognized or asserted on an international stage in the realm of health? The decision on that front at this particular moment in time helps to clarify the limits of this autonomy, particularly in relation to more regional or international approaches to disease. Dr. Richet responded that the relationships of territories with international organizations continued, for the time being to be established by *his*

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<sup>285</sup> SHD 2013 ZK 005 101 « Procès-verbal de la Commission consultative du Service de Lutte Contre les Grandes Endémies » Dakar, 7-10 Juillet 1958. », 2.

<sup>286</sup> My translations. Richet, 1965, 236.

<sup>287</sup> SHD 2013 ZK 005 101 « Procès-verbal de la Commission consultative du Service de Lutte Contre les Grandes Endémies » Dakar, 7-10 Juillet 1958. », 9.



service (my italics), the *Service Commun*.<sup>288</sup> After some discussion, delegates agreed to continue with this structure. The consequences of coordination were thus seen not just as a question of how to balance newfound autonomy with the connections built through empire, but also as a question of how the francophone territories of West and Central Africa would be more broadly positioned in the realm of international health.

Notably, the limits of this centralizing coordination role became clear on the question of finances. Later in the same 1958 conference, Eouangnin of Dahomey made clear one of the reasons he was interested in how relations with international organizations would work: he was hoping that local costs associated with research and experimentation related to a malaria program, financed in part by the WHO and UNICEF, would be taken under the umbrella of the *budget général*, rather than that of his territory, with the argument that the results of this program would benefit the entire group. A presiding French official, Risterrucci, replied that current legislation would not allow this; the malaria program was based on accords between Dahomey and international organizations, and if Dahomey was not able to uphold the part of the accords that called for responsibility for some local costs, it had the capacity to end the program. The *Service Commun* would not be able to step in on its behalf.<sup>289</sup> These conversations highlighted a new tension and uncertainty over the delineation of responsibility and control between territorial African governments and French administration and between the individual African territories and the group of them.

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<sup>288</sup> SHD 2013 ZK 005 101, « Procès-verbal », 9. The meeting minutes are not presented as direct quotes; it was recorded that Richet referred to ‘son service,’ or his service as the intermediary for international organizations.

<sup>289</sup> Risterrucci was *Gouverneur Inspecteur Général des Affaires Administratives*. SHD 2013 ZK 005 101, « Procès-Verbal », 19.

Ministers of Health in the territories of French Equatorial Africa met as part of a broader ‘Conférence Interterritoriale’ in Brazzaville in April 1958.<sup>290</sup> They discussed plans to reorganize the structure of the *Service de Lutte contre les Grandes Endémies* and present the proposed new structure to the Grand Council of AEF. These discussions responded to controversy that arose between November 1957 and March 1958 over the proper breakdown between the mobile service budget and authority at the inter-territorial versus individual territorial level. While the Grand Council had in November 1957 voted to decentralize the service as much as possible, and doubled down on this position in January 1958, representatives from Moyen-Congo (future Congo-Brazzaville) pushed back against this stance and argued for maintaining strength (budgetary and otherwise) in the *Service Commun* at the level of the group of territories. Ministers of Health thus met in April 1958 to discuss this ongoing tension. The Minister of Health of Chad, Baba Hassan, presented the proposal for the restructuring and focused on ways to strengthen the avenues for centralized planning and coordination between the territories. This included the installation in Brazzaville, at the level of the group of territories, of a stronger ‘Direction du Service’ in charge of technical and administrative management, scientific research and training of personnel.<sup>291</sup> Secondly, they called for the creation of a *Commission Administrative* constituted by the High Commissioner, the Ministers of Health of the four territories and the director of the service, entrusted with establishing the program of action, the budget of the service and the distribution of funds.

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<sup>290</sup> SHD 2013 ZK 005 101. ‘Commission de Travail des problèmes Relatifs au Service de Lutte Contre les Grandes Endémies.’

<sup>291</sup> SHD 2013 ZK 005 101 ‘Commission de Travail des problèmes Relatifs au Service de Lutte Contre les Grandes Endémies”, 2.

In 1959, the structure of the mobile health team system continued to evolve and be further entrenched in their individual territorial form, in the wake of the political changes of the creation of the French Community, which decisively brought an end to any remnants of the federations of French West Africa and French Equatorial Africa. At this time, the teams became fully ‘national’ in their orientation, doing away with the remaining degree of inter-territorial coordination that had existed since 1957. Each African state now had an individual service called the *Service national des Grandes Endémies* (SGE). These services fell under the authority of the each national Minister of Public Health, with no institutionalized mechanism to coordinate their work.<sup>292</sup>

The Ministers of Health of the African states continued to meet, however, along with French officials to discuss and create avenues for inter-territorial work. In October of 1959, a meeting in Bangui of officials from the former French Equatorial Africa created a permanent ‘secretariat’ responsible for collecting epidemiological information from the states and putting out an annual report on the group data. The responsibility for the task initially fell to the public health staff of Gabon.<sup>293</sup> This format, while preserving the idea of shared epidemiological concerns, certainly took a step back from the previous vision of a centralized and coordinated response at the federation-level. Ministers from West Africa similarly met twice in Bobo-Dioulasso in June and September 1959 to discuss coordination going forward.<sup>294</sup> These discussions would take on new dimension as all of the involved territories became independent nation-states in the year ahead. Reflecting back on this period, 1957-1959, which he

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<sup>292</sup> Richet (1965), 236.

<sup>293</sup> *Rapport Final de la Conférence des Ministres de la Santé des États Équatoriaux*. Yaoundé, les 21, 22, 23 août 1963., p. 14. World Health Organization Library, Geneva, Switzerland.

<sup>294</sup> Richet (1965), 237.

characterized by “the splitting up of the large federal services, their ‘cutting up’ by territory,” Dr. Pierre Richet wrote thankfully about the authorities and politicians who hesitated in the face of these changes, as “they were more and more persuaded that it was impossible to simply cut into eight independent fragments, [in French West Africa] one per Republic, a Service that was from 1939-1959 so closely coordinated, and that benefited from such unified direction, doctrine and action at the federal level.”<sup>295</sup>

### **Towards Regional Health Organizations**

In April 1960, health ministers of former territories of French West Africa met in Abidjan, Côte d’Ivoire and formed the inter-state health organization OCCGE, *l’Organisation de Coordination et de Coopération pour la Lutte contre les Grandes Endémies*. In addition to the seven original African member states, France also became a member state and contributed substantial funding and personnel to the organization. Beyond centralized administration through *un Conseil d’Administration* and the office of the permanent Secretary General, the organization also would serve as an umbrella for four scientific centers and institutes based in Upper Volta (present day Burkina Faso), Mali and Senegal.<sup>296</sup> Dr. Pierre Richet became the first Secretary General of the Organization, a position that he would hold until 1970, when Malian doctor Cheick Sow took over the position. Even then, Richet retained the title of ‘honorary director.’<sup>297</sup> Writing retrospectively in 1980 on the founding of the organization, Richet noted:

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<sup>295</sup> My translations. Richet (1965), 236.

<sup>296</sup> Ibid, 237.

<sup>297</sup> Pierre Richet, « La lutte contre les grandes endémies tropicales en Afrique Noire Francophone, » *Afrique Contemporaine* Nov-Dec. (1980) : 3.

In recreating, in April 1960 in Abidjan, in the form of OCCGE, a federal type of organization capable of pursuing the life-saving work of the former SGHMP, they made our pithy expression theirs: ‘Germs, viruses, vectors defy the geographic boundaries drawn by men and local particularisms ; and our slogan: disease and suffering know no borders.’<sup>298</sup>

Richet’s saw the organization not as an entirely new chapter of health work among independent African states, but as a move to *recreate* some of what had existed before, specifically by striving to replicate some basis for inter-territorial coordination of the mobile health service that had existed through the centralized federation of French West Africa before the implementation of the loi-cadre. Richet also asserted this much-repeated idea that the urgent need for this type of coordination grew out of the lack of regard of viruses and diseases to politically delineated national borders. Richet did not speak, in this case, to the question of other borders, those that were not shared by former French African states, and he certainly did not touch upon the political reasons for which Guinea, a part of the federation of French West Africa, was not joining this organization as an independent state.<sup>299</sup> OCCGE’s ‘borderlessness,’ asserted on the grounds of the fundamental public health concerns of how diseases spread, was at the same time deeply implicated in the framework of the French colonial administration of health services as well as the particular political geography that grew out of decolonization.

While OCCGE quickly formed a West African health block, African public health officials from the former French colonies also gathered in larger groupings in coordination with French officials. In May 1961 in Paris, public health officials from Africa met in a “Conference

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<sup>298</sup> Richet (1980), 5.

<sup>299</sup> In the 1958 referendum in African territories to join the French Community, the people of Guinea voted ‘no’ and as a result, France immediately cut ties and support. Guinea did join the organization in 1962: Richet 1965, 240. Togo became a member in 1964: Richet 1965, 241.

of Ministers of Public Health of French-speaking States.”<sup>300</sup> Bernard Chenot, Minister of Public Health and Population for the Republic of France, presided over the conference, assisted by Jean Foyer, Secretary of State of Relations with the states of the Community and Jacques Foccart, Secretary General of the Community.<sup>301</sup> Additional delegates from France attended along with Ministers of Public health and/or other health officials from Cameroon<sup>302</sup>, Madagascar and all of the former territories of AEF and AOF, now independent states, with the exception of Guinea. Dr. Pierre Richet, in his capacity as the Secretary General of the newly created West African health organization, OCCGE, also attended the meeting as an observer.

Jean Foyer opened the conference, framing the question of cooperation against disease as something that benefited all parties, arguing that, “as long as there existed, in any area of the world, an epidemic outbreak, no country, as developed as it might be, will be sheltered from a possible aggression.”<sup>303</sup> He asserted the interest of France in providing bi-lateral aid to support health programs in the countries, while also pointing out that the preference would be to fund preventative medicine or ‘médecine de masse,’ as well as research, given the high costs and personnel needs of hospitals.<sup>304</sup> Foyer characterized the health collaboration as the “pursuit of a work that had been undertaken by France for many years,” but he added that it would not

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<sup>300</sup> SHD 2013 ZK 005 224 “Conférence des Ministres de la Sante Publique des Etats d’Expression Française : Paris-Mai 1961, Fascicule 1-Les Problèmes Généraux » The conference is also referred to in the report as ‘la Conférence des Ministres de Santé des Etats Africains et Malgache de langue française.

<sup>301</sup> Foccart played a central role in France’s dealings, often dubious in nature, with African leaders in the newly independent states. For an overview of these policies and workings from independence forward, often called, ‘Françafrique,’ see Tony Chafer, ‘Chirac and ‘la Françafrique’: No Longer a Family Affair,” *Modern & Contemporary France* Vol. 13 No. 1 (2005): 7-23.

<sup>302</sup> Cameroon delegates to the conference were Pierre Kandem-Ninyim, Ministre d’Etat chargé de la Santé Publique, Dr. Jean Claude Happi, Directeur du Cabinet, and Dr. Benoît Essougou, Conseiller.

<sup>303</sup> SHD, 224- Fascicule 1, p. 6.

<sup>304</sup> SHD, 224-Fasicule 1, p. 7.

suffice just to maintain or continue this work, “it must broaden and develop.” He added that this would entail, not just a connection between France and each of the states, but a ‘close cooperation’ between all of the African states and ‘us.’<sup>305</sup> He noted the succession of meetings, beginning in 1959, of the former territories of AOF, which began to set up this structure, and referred to the former territories of AEF also taking the first steps towards this coordination with the secretariat set up in Gabon.

After the welcoming statements, Ministers of Health from the African states gave presentations on the public health systems in their respective countries. These comments reflected the uneven development and investment in health services across French territories. Minister of Health of Cameroon, Pierre Kamdem Ninyim<sup>306</sup> began with the overall conclusion that Cameroon already had a “sufficiently robust infrastructure” and that their intention was to “improve on the existing establishments.” He reinforced that Cameroon had no intention “of abandoning the work undertaken by the *Services d’Hygiène et de Prophylaxie*, which had already proven their worth’ and rather strove to ‘reinforce the preventive role of medicine.”<sup>307</sup>

Not all presentations were as straightforwardly positive about the legacy of French medical administration in the former colonies. The Minister of Public Health of Congo

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<sup>305</sup> SHD, 224-Fascicule 1, p. 9.

<sup>306</sup> Kamdem-Ninyim’s tenure as minister would only last one month more, until June 1961, and his life not much longer. He was executed by firing squad in 1962 after being accused of being involved in the murder of a local deputy, as part of the ongoing political violence and unrest in Cameroon in the 1960s. Mark W. DeLancey and H. Mbella Mokeba, ed., *Historical Dictionary of the Republic of Cameroon*, 2<sup>nd</sup> edition (Metuchen, NJ and London: The Scarecrow Press, 1990), 114. For extensive background on Kamdem-Ninyim, see: Meredith Terretta, *Nation of Outlaws, State of Violence: Nationalism, Grassfields Tradition, and State Building in Cameroon* (Athens, Ohio: Ohio University Press, 2014.).

<sup>307</sup> SHD, 224-Fascicule 1, p. 11.

Brazzaville, Raymond Mahouata<sup>308</sup>, discussing the vast need for investment in health infrastructure and personnel in his territory argued that “it must be recognized that France left us with a meager legacy, regarding medicine.”<sup>309</sup> He asserted the critique of this legacy as a way to express an urgency for greater investment from France going forward, saying that the technical assistance conventions passed between France and Congo gave him hope that “the metropole would come to our rescue.” Mahouata framed this in the gravest of terms, saying that any delay in responding to the need for more medical personnel could only be considered “an infringement on human life and the future of our nation.” It was up to France, he added “to do the impossible and make sacrifices.”<sup>310</sup> The Minister of Public Works of Chad, N’Gantar, representing the Minister of Health of the country in this meeting, adopted a similar stance. He outlined the serious problem of personnel for this country and asked that France and other states of the French Community help with the need for doctors, nurses, mid-wives and ‘assistantes sociales.’ He projected this need growing greatly in the decades ahead. After outlining these needs, he adopted a reprimanding tone towards France, observing that “France seems to have great difficulty responding to our growing needs...”<sup>311</sup> Turning to the interwoven histories of France with his country, he added that “each time that France has called our children to serve in it ranks for the defense of liberty and of fundamental freedoms, we have always been there.

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<sup>308</sup> Mahouata was the first Congolese biomedical doctor. Headrick, 428.

<sup>309</sup> SHD 2013 ZK 005 224-Fascicule 1, p. 18

<sup>310</sup> SHD 2013 ZK 005 224-Fascicule 1, p. 18.

<sup>311</sup> M. Dannaud, Directeur des Affaires Culturelles et Techniques for the French delegation replied to this complaint later in the meeting, arguing that France would provide needed personnel in the short-term for certain countries, such as Chad, but that the ultimate goal was to support training of lower-level health personnel in-country, while focusing on providing for more specialized/high-level expertise, SHD 224, Fascicule II, 14-17.



Today we call on France to help us protect the health of our fellow citizens and in particular that of our children.”<sup>312</sup>

The language of coordination and post-independence cooperation used by African officials thus operated on different registers based on the specificities of local or colonial histories. France had indeed invested more in the health infrastructure of Cameroon, when considered as amount spent per inhabitants, compared to its neighbors of AEF, and in comparison to AOF as well.<sup>313</sup> Thus, while the Minister of Health of Cameroon called essentially for an amplification of the French system of medicine after independence, the Minister of Congo worked to evoke a sense of debt owed in the name of an ongoing bilateral avenue for aid from France.<sup>314</sup> (See Table 1)

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<sup>312</sup> SHD 224, Fascicule 1, 43.

<sup>313</sup> Lachenal 2014, 78.

<sup>314</sup> A French survey of medical personnel and French investment in the former states of AEF and in Cameroon in 1961 ranked the countries in terms of its needs for ongoing investment in personnel from France. The report ranked Cameroon as the best equipped and projected that Cameroonian doctors (including those currently training in France) would be able to replace technical assistance doctors in roughly ten years. Congo and Gabon came in the second ranking in terms of existing doctors and possibilities for replacement. Central African Republic and Chad came last, with estimates that the countries would not have sufficient doctors for at least 25 years and only then would a reduction in technical assistance be viable. SHD ZK 005 406, « Enquête sur la Coopération Technique en Matière Sanitaire au Congo, Gabon, Centrafrique, Cameroun et Tchad, » 4 octobre-6 novembre 1961, Médecin Colonel Diagne

**Table 1*****Distribution of State Medical Personnel in Cameroon, Congo, Gabon, Central African Republic and Chad in 1961<sup>315</sup>***

	Cameroon	Republic of Congo	Gabon	Central African Republic	Chad
Estimated Population	3,200,000	800,000	420,000	1,200,000	2,800,000
State doctors per capita	1: 38,095	1: 19,512	1: 11,351	1: 41,379	1: 77,777
Percentage of Doctors in Mobile Health Service	17.8%	6%	5.4%	17.8%	11.4%
French Military doctors*	54	33	25	23	33
Additional doctors funded by France	2		12	3	2
<b>Total French-funded Personnel</b>	<b>75**</b>	<b>74</b>	<b>57</b>	<b>57</b>	<b>72</b>
National doctors ***	28	8	unknown	3	1
Nationally-funded foreign personnel	2		22		3
<b>Total Nationally-funded personnel</b>	<b>1343</b>	<b>780</b>	<b>800</b>	<b>521</b>	<b>436</b>

\*French personnel funded through the Ministry of Cooperation

\*\*Gardinier gives this number as 80 in 1961.

\*\*\* Includes both ‘Docteurs en médecine’ and ‘Médecins Africains’ who completed training at Dakar School of Medicine, working for the state. In addition to the 28 in Cameroon, 26 *médecins africains* were studying in France in 1961. An additional 6 Cameroonian doctors worked in private practice. Note that numbers for Cameroon only include personnel in East Cameroon and not in the former British West Cameroon. The mobile health services in each country were run by a French military doctor, with the exception of the Republic of Congo, where the service was headed in 1961 by a Congolese *médecin africain*.

<sup>315</sup> SHD ZK 2013 005 406, « Enquête sur la Coopération Technique en Matière Sanitaire au Congo, Gabon, Centrafrique, Cameroun et Tchad, » 4 octobre-6 novembre 1961, Médecin Colonel Diagne

Others, such as Minister of Public Health, Bounougou, of Gabon, called for aid and coordination above and beyond the bilateral level, instead seeking technical support at a regional level. In describing the service of mobile teams in his country, he reported that “the only difficulty concerns the lack of technical directives. There is the WHO, of which the experts are very useful to us in the evaluation of needs and the elaboration of programs, but for the problems that arise daily, Gabon does not have sufficient qualified personnel to issue authoritative solutions.”<sup>316</sup> Bounougou suggested the creation of an organization primarily technical and statistical in nature which could study health problems and propose solutions. He envisioned an organization that would not so much meddle directly in the administration of national mobile services, but one led by a qualified expert who could work in connection with all of the states, proposing solutions to epidemiological problems facing the countries. He concluded that he envisioned the organization “led by a doctor possessing an unquestionable moral and professional authority” based in Paris, which would still allow for exclusive responsibility for decisions over which plans were executed to the Minister of Health. He added that “the creation of this technical organization will not at all prevent the continued functioning of the permanent *Secrétariat permanent des grandes endémies* created by the four states of Equatorial Africa.”

The Minister from Chad also remarked on the need for coordination between states. He expressed the wish that the *Secrétariat d’Afrique Centrale*, based in Gabon at the time and coordinating the *grandes endémies* programs would collaborate closely with the West African O.C.C.G.E. He continued, “we wish to see these two organizations spread their field of action and become a true high commission of coordination of public health in Africa, a true common

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<sup>316</sup> SHD 2013 ZK 005 224, Fascicule 1, 23.

market of health” (un vrai marché commun de la santé”). He placed this vision in the context of his ‘disappointment’ over the slowness and inefficiency of the specialized organizations of the United Nations in Africa. He ventured that “if, through a common action, we could get posts and regional offices better spread between Francophone-trained staff and Anglophone-trained staff, we could more easily shake this inertia.”<sup>317</sup>

In comments he made later that day following the presentations by the Ministers of Health, Dr. Aujoulat<sup>318</sup> looped back to this comment by the Minister from Gabon to speak to the possibilities for inter-state coordination. He referred to OCGGE, the regional health organization created by the states of the former AOF, and how it fulfilled this role, but he posed the idea: “but perhaps could one go further and envision, in effect, that at a scale still larger and at the level of what one of you called ‘Le Marché Commun de la Sante,” referring to the comments by the Chadian Minister. He imagined aloud if it would be possible to form ‘committees of experts’ who follow the evolution of epidemiological and therapeutic situations, and passing through the common organizational structures that did exist, could respond directly to requests by states and provide the technical direction required. Aujoulat pointed to *l’Ecole du Pharo* in France, with its research resources and experts, as a source for this kind of work, noting that the committees of experts they could provide would be “comparable to those that work at the level of international organizations” but would have the added benefit of working at a faster pace, without the delays imposed by international organizations.”<sup>319</sup>

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<sup>317</sup> SHD 2013 ZK 005 224-Fascicule 1, 44.

<sup>318</sup> Aujoulat was attending meeting in the capacity of ‘technical advisor’ as part of the French delegation.

<sup>319</sup> SHD 2013 ZK 005 224, “Conférence des Ministres de la Sante Publique des Etats Indépendants d’Expression Française : Paris-Mai 1961, Fascicule II-La Coopération Technique & Sanitaire, » 8-9.

This kind of language about the inefficient, cumbersome nature of international organizations would reoccur in the early 1960s among both African and French doctors in their discussions about health coordination. While international organizations—undoubtedly in this context referring largely to the World Health Organization—might embody the shared spirit of transcending state borders in confronting disease, they were seen as not fully up to the task. In this meeting and others, public health officials and doctors working in this shared French-African space instead focused on what other forms of regional, cross-border cooperation could be possible. At this particular moment in 1961, with the francophone West African health coordination newly institutionalized through OCCGE, and ongoing discussions about how the Central African states might proceed, there was also a significant imagining going on of what bridging these two regional spheres, with the backing of France, might look like.

The creation of a concrete system to marry these infrastructures for regional cooperation ultimately did not develop quickly, but Central African public health officials did take further steps to strengthen their own regional coordination. Ministers of Health of the former territories of French Equatorial Africa had met bi-annually in the first years of independence, with Cameroon acting as an observer.<sup>320</sup> In January 1962, health ministers of these four states and Cameroon met in Fort-Lamy to continue discussions about coordination. They reviewed the 1960 report from the permanent secretariat in Gabon that had been entrusted with coordinating health information between the territories and found its results and capacity to do more quite

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<sup>320</sup> WHO. *World Health Organization, Regional Committee for Africa, Tenth Session, Accra 8-13 August 1960, Reports and Minutes*, AFR/RC10/Min/4/Rev. 1, 17.

lacking. The Ministers of Health decided in this meeting to turn the permanent secretariat into a rotating one, with each state taking a turn at bearing the responsibility.<sup>321</sup>

In addition to the meeting in Chad, the health ministers also crossed paths in attending a meeting of the West African OCCGE, and had discussed informally in this setting the need to create the basis, as soon as possible, for a similar organization. They convened again in 1963, bringing together public health ministers of the five countries-Cameroon, Congo-Brazzaville, Gabon, Central African Republic and Chad, in Yaoundé, Cameroon in August to pursue the creation of their own inter-state health organization, the *Organisation de Coordination et de Coopération pour la lutte contre les Grandes Endémies en Afrique Central* (OCEAC).<sup>322</sup>

Minister of Public Health of Cameroon, Dr. Simon-Pierre Tchoungui, opened this 1963 conference, emphasizing the purpose of the conference as being to discuss modes of cooperation in the fight against “les endémo-épidémies.” Tchoungui situated the meeting in the context of the “vast movement of grouping (regroupement) and cooperation that is taking place in Africa,” but underlined the particular urgency of cooperation in the realm of public health in which, ‘all isolated effort is irreparably doomed to failure.’ Tchoungui referred to the prior creation of a rotating secretariat between the states, meant to collect and diffuse health information, but characterized this arrangement as a ‘first step,’ and ‘only a beginning.’ “What we need is a stable organization, perfectly structured and equipped, capable of providing the

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<sup>321</sup> WHO. *Rapport Final de la Conférence des Ministres de la Santé des États Équatoriaux*, Yaoundé, les 21, 22, 23 août 1963, Organisation de Coordination et de Coopération contre les Grandes Endémies en Afrique Centrale. 14.

<sup>322</sup> Ibid, 5. For clarity’s sake, I refer to the organization here as OCEAC, its name after 1965 and current name. The original proposed and working name of the organization was OCCGEAC: Organisation de Coordination et de Coopération pour la lutte contre les Grandes Endémies en Afrique Centrale.

exchange of information, technicians to study methods of action, harmonization, legislation and even the organization of common campaigns..”<sup>323</sup>

Reflecting on the full scope of health coordination that had arisen between French-speaking African states in the previous three years, he posed the hypothetical question or objection to the order of the current meeting: why wouldn't the Central African states simply join the already established West African Organization of OCCGE with its headquarters in Bobo-Dioulasso, Upper Volta? Dr. Tchoungui outlined the 'geographic considerations' that made this union unreasonable, among them that the Central African states were a far distance from the OCCGE headquarters and they didn't share common borders with the other member states of the organization, meaning that even “if the problems are similar, it seems all the same difficult to resolve them through a concerted effort.” He contrasted these circumstances with the proposed member states of OCEAC: “we have the same health problems and we adhere to the same customs union.”<sup>324</sup>

In addition to these observations about the relationship between the West and Central African states, however, Dr. Tchoungui also made an important comparison with another form of regional health cooperation in Africa: the Regional Office for Africa of the World Health Organization. He pointed out the example of the office, which was located in Brazzaville, therefore *within* OCEAC territory, and characterized it by its “enormous administrative machine.” He asked whether it was thought necessary by the group to create another organization “as cumbersome.” He saw this possibility if the five states of Central Africa were

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<sup>323</sup> My translations. WHO. *Rapport Final de la Conférence des Ministres de la Santé des États Équatoriaux*. Yaoundé, les 21, 22, 23 août 1963, 6.

<sup>324</sup> WHO. *Rapport Final de la Conférence des Ministres de la Santé des États Équatoriaux*. Yaoundé, les 21, 22, 23 août 1963. 7.

to join the West Africa OCCGE, warning that in this scenario the existing organization risked becoming “hypertrophic.”<sup>325</sup> Instead, he spoke for the group saying “what we desire is a simple organization, inexpensive but effective and I think that the example of OCCGE of West Africa can serve for us as a model.”

Dr. Tchoungui also drew justification for the creation of a regional health organization from the scientific research resources in the group of states including: the Pasteur Institute of Brazzaville, the Tropical Veterinary Institute in Fort-Lamy, Chad, and the Medical Research Institutes of Cameroon including the Pasteur Institute, the Center for research on Helminthiasis and Onchocerciasis in Kumba, the nutrition branch of I.R.C.A.M<sup>326</sup>, and the entomology branch of the National Malaria Eradication Service.<sup>327</sup> Cameroon was also in early stages of planning for the creation of a medical school at the Federal University of Cameroon and for an Institute of Public Health, which Dr. Tchoungui envisioned would help train personnel specialized in the fields of preventative and rural medicine.

The public health officials in the meeting also reflected on the need to strengthen the existing efforts they had made towards coordination in the form of the rotating secretariat. Dr. Ziegler of the Chad Delegation reported, in fact, that there was little to report. The results were ‘meager, if not nonexistent’, and ‘this system, without a leader, with a guiding idea’ was totally inadequate for a coordinated approach to disease control.<sup>328</sup>

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<sup>325</sup> Ibid, 7.

<sup>326</sup> Institut de Recherches du Cameroun.

<sup>327</sup> Ibid, 7-8.

<sup>328</sup> Ibid, 12.



In the further discussion of creating a more permanent regional health organization, Dr. Tchoungui of Cameroon again took the floor and proceeded to place the work of the conference within a historical narrative: that of the creation of the mobile medical system under Dr. Eugène Jamot. He gave an origin tale of Jamot's work in combatting sleeping sickness in the 1920s in Cameroon and the subsequent creation in 1944 of the multi-faceted mobile health teams in French West Africa, French Equatorial Africa, and Cameroon. Throughout the speech, Tchoungui peppered his language with asides, of "as you all know," recognizing that the history was well-known by the conference attendees. It was a historical narrative resurrected for performance value, more so than information.<sup>329</sup> He traced a similar story of that produced at earlier dates about the significance of the *loi-cadre*, as a change that disrupted the centralized organization of the teams across territories. And with independence, although 'in theory,' the mobile medicine work continued, that political and health authorities of the independent states quickly realized that coordination between countries had been lost and was necessary.<sup>330</sup> Tchoungui reviewed the efforts of the states of former AEF plus Cameroon to create first a rotating, and then permanent, secretariat to coordinate between the states, arguing that the time had come to create a specialized organization with personnel fully focused on the task.

The delegation to the meeting from Cameroon had prepared proposed regulations and statutes for the new organization, based on the structure of the West African OCCGE, and

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<sup>329</sup> Guillaume Lachenal, "Célébrer le passé, construire le futur: l'indépendance et le microcosme médical au Cameroun," in *Les Indépendances en Afrique: l'événement et ses mémoires: 1957/1960-2010*, ed. Odile Goerg et al. (Rennes: Presses Universitaires de Rennes, 2013), 353-376. Lachenal analyzes the installation of a statue of Jamot in Yaoundé in 1959, framing the event as a ritual that involved a rewriting of decolonization in Cameroon as a peaceful transition which would then support a post-colonial future of on-going close French-Cameroonian ties in the medical world.

<sup>330</sup> WHO. *Rapport Final de la Conférence des Ministres de la Santé des États Équatoriaux*. Yaoundé, les 21, 22, 23 août 1963, 13.

brought them to the group to be discussed piece by piece. The meeting appears somewhat pre-determined in this regard, and the Cameroonian delegation played a defining role in shaping how this conversation about the parameters of the organization would proceed. The President and Secretary General of the West African OCCGE had consulted directly with health officials in Cameroon about the structuring of their organization before the meeting of the Central African health ministers.<sup>331</sup> The composition of the Cameroonian delegation is thus worth noting. Of the four official delegates representing the country, two were Cameroonian and two were French. The Cameroonians were Dr. Tchoungui, the Minister of Public Health and Dr. Jean-Claude Happi, Director of Public Health. The French were Dr. Aretas, ‘Technical Advisor’ to the Minister of Public Health, based in Yaoundé and Dr. Bereni, the Director of the mobile health service in Cameroon.<sup>332</sup> Dr. Aretas, the French advisor to the Ministry of Public Health was the one who first introduced the proposals to the group, highlighting the kinds of dynamics that were so very formative to the creation of OCEAC and its West African counterpart: a French doctor, in his capacity as part of the ‘Cameroonian Delegation’ spoke to a meeting of Central African Ministers of Health about proposals to create a new regional health organization among them.

The administration of the organization would involve the Administrative Council composed of the Ministers of Health of the member states, with a president elected by the council for a term of one year. The ‘Secrétariat Général’ would be based in Yaoundé and consist of a Secretary General elected by the Administrative Council with a technical deputy, an

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<sup>331</sup> Ibid, 16.

<sup>332</sup> Other Yaoundé-based medical personnel were at the meeting as observers: Dr. Ernest Kodo (Grandes Endémies), Médecin Lt. Colonel Gamet (Directeur Institut Pasteur), Médecin Commandant Pele (Section Nutrition-Institut de Recherches du Cameroun), Dr. Torfs (Conseiller O.M.S.), Dr. Abane (Chef du Service National d’Eradication du Paludisme), Dr. Le Mao, Grandes Endémies, Yaoundé.

administrative deputy, and junior operational personnel. The Secretary General would play a key role in ‘the execution of decisions and instructions of the Council of Administration,’ and Aretas pointed to Dr. Pierre Richet’s role in leading the West Africa OCCGE, calling him the ‘kingpin’ of that organization. The new Central African organization would also include medical research centers and eventually training centers.<sup>333</sup> The organization did state within its statutes that it would be open to any other states of Central Africa that wished to join, on the condition of unanimity by all member states.<sup>334</sup> The meeting also affirmed that OCEAC would have close and permanent connections to West African OCCGE, as well as with international organizations dealing with health such as the WHO and UNICEF.<sup>335</sup>

The funding for the organization would derive from contributions from member states, the proportion of which would be determined annually by the Administrative Council, as well as from international and bilateral assistance. Dr. Aretas talked in this meeting about how the delegates hoped France would become a member state, as it was of the West Africa OCCGE, and contribute financially to a similar degree.<sup>336</sup> France ultimately declined membership in the Central African organization, but agreed to make substantial contributions towards its functioning, particularly in the realm of personnel.<sup>337</sup>

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<sup>333</sup> The Cameroonian delegation announced plans for the creation of an Institute of Public Health in the country to train personnel specialized in preventative medicine.

<sup>334</sup> WHO. *Rapport Final de la Conférence des Ministres de la Santé des États Équatoriaux*. Yaoundé, les 21, 22, 23 août 1963, 17.

<sup>335</sup> Ibid, 20.

<sup>336</sup> Ibid, 18.

<sup>337</sup> CADN 743PO/1/168 Yaoundé le 10 Juillet, 1965, Francis Hure, Ambassadeur de France au Cameroun à Monsieur Raymond Triboulet, Ministre Délégué Chargé de la Coopération, Direction de la Coopération Culturelle et Technique : Première Conférence de l’Organisation de Coordination et de Coopération contre les Grandes Endémies en Afrique Centrale. This letter refers to letter no. 53349 dated December 12, 1963 sent by the newly

Debate then took place in this meeting as to exact break down of member state budget contributions: a preliminary proposal of breakdown according to population met opposition, particularly from the Chadian delegation, which insisted that the actual health budgets of each state be taken into account. Others in turn opposed this idea, arguing that the overall budget of each state was more important in representing its economic situation. By any calculation, Cameroon would be paying the lion's share of the budget due to its population and resources.<sup>338</sup> Ultimately, the group settled on a distribution based on the average of the percentage contributions based on population and budget (notably the same formula followed by West African OCCGE), which resulted in the following breakdown: Cameroon: 42.55%, Chad 20.77 %, Central African Republic 13.07 %, Gabon 12.9 %, Gabon 10.71 %.<sup>339</sup>

The meeting defined the precise goals of the organization: 1) "to establish and coordinate all programs of action aimed at the control and eradication of the major endemic and epidemic diseases (grandes endémo-épidémies) striking the territory of the member states: trypanosomiasis, leprosy, treponematosi, malaria, onchocerciasis, schistosomiasis, trachoma, tuberculosis, etc...2) To pursue all studies, research, prospections or investigations necessary to successfully fight against these endemic and epidemic diseases."<sup>340</sup> The Cameroonian delegation proposed to take on the charge of beginning to establish the organization until the

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formed OCEAC to the French Minister of Cooperation proposing permanent membership for France in the organization ; the letter also refers to France's ultimate decision to decline being a permanent member.

<sup>338</sup> WHO. *Rapport Final de la Conférence des Ministres de la Santé des États Équatoriaux*. Yaoundé, les 21, 22, 23 août 1963, 23. Population numbers given here are as follows: Cameroon 4,350,000 inhabitants, Chad 2,600,000, Central African Republic 1,200,000, Gabon 450,000 and Congo 760,000.

<sup>339</sup> Ibid, 24.

<sup>340</sup> Ibid, 30.

member heads of state formally ratified its creation. Dr. Tchoungui of Cameroon closed the conference with the words: “Vive les Etats d’Afrique Centrale, Vive l’O.C.C.G.E.A.C.”<sup>341</sup>

OCEAC subsequently held its first official meeting of health ministers in July 1965 in Yaoundé, in which the members settled the leadership of the organization. Notably, John Ngu Foncha, hailing from the Anglophone West Cameroon, and Vice President of the Federal Republic of Cameroon, presided over the meeting.<sup>342</sup> The health ministers elected Dr. Jean-Claude Happi, now Commissioner General of Public Health for Cameroon, as President of the organization for the established one year term. The technical leadership of the organization were French military doctors. René Labusquière<sup>343</sup> became the Secretary General. Dr. Jean Dutertre was named his second in command.<sup>344</sup>

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<sup>341</sup> Ibid, 28.

<sup>342</sup> CADN 743PO/2/168, Yaoundé le 10 Juillet, 1965, Francis Hure, Ambassadeur de France au Cameroun à Monsieur Raymond Triboulet, Ministre Délégué Chargé de la Coopération, Direction de la Coopération Culturelle et Technique : Première Conférence de l’Organisation de Coordination et de Coopération contre les Grandes Endémies en Afrique Centrale.

<sup>343</sup> Like so many of the French doctors stationed in West and Central Africa in the 1960s through under the framework of “Coopération,” Labusquière had already had a long career in colonial medical services in the region. From 1946-1954, he had been stationed in Cameroon and in Oubangui-Chari (Central African Republic after independence) working with the mobile health teams in each territory. In the late 1950s, he worked as the head of the leprosy service for the *Service Général d’Hygiène Mobile et de Prophylaxie* of French West Africa in Dakar, which led him on work throughout the territories of French West Africa. After the independence of the French African states, he served as the head of the national mobile health service in Upper Volta: M.F. Lechat and H. Journiac, “Obituaries: René Labusquière, 1919-1977,” *International Journal of Leprosy* 46 (1978): 70-71. See also: René Labusquière, *Santé Rurale et Médecine Préventive en Afrique: Stratégie à opposer aux Principales Affections*, 2<sup>nd</sup> edition (Paris : Sant-Paul à Bar-le-Duc, 1975).

<sup>344</sup> Labusquière and Dutertre were designated as ‘médecin militaire,’ an administrative deputy, Junin, was also appointed as ‘Capitaine d’Administration du Service de Santé.’ All three would serve ‘en position hors cadres, au titre du Ministère de la Coopération.’ CADN 743PO/2/168, Yaoundé le 10 Juillet, 1965, Francis Hure, Ambassadeur de France au Cameroun à Monsieur Raymond Triboulet, Ministre Délégué Chargé de la Coopération, Direction de la Coopération Culturelle et Technique : Première Conférence de l’Organisation de Coordination et de Coopération contre les Grandes Endémies en Afrique Centrale. The salaries of the French personnel were funded through the French Ministry of Cooperation, separate from the main budget of the organization. The proposed budget for the first year of operation was 23,535,000 CFA.

Comments in the first OCEAC technical conference in 1965 highlighted the politically delicate balance this leadership arrangement presented. In his opening remarks, Dr. Happi spoke about the need to break down the divisions of borders and concluded, “we wish to live independently, we do not want to live in isolation.”<sup>345</sup> Secretary-General Labusquière made sure in this meeting to emphasize that OCEAC was not attempting to resurrect the former colonial mobile health service and did not seek to intervene directly in the affairs of the member states, but to always focus on improving the national mobile health services.<sup>346</sup> The leadership of OCEAC forged a language that emphasized the sovereignty of the African states and health coordination as part of this sovereignty, while also institutionalizing a clear place for French medical leadership.

The joint Cameroonian and French leadership of OCEAC at its inception thus embodied many of the political, social and economic relationships between France and its former African colonies after independence. OCEAC exemplified these ties of ‘coopération’ between individual African states and France, while showing how this context also led to the forging of connections between African states. Situating this institution only on this French-African axis is to bypass the important ways in which it also brought newly independent African states together and promoted its region as a scale of public health intervention—a scale for coordinating health campaigns, for collecting epidemiological data and certainly for gathering funding. French doctors paradoxically remained central in the forging of these ties, but the

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<sup>345</sup> WHO Library, *Rapport Final de la Première Conférence Technique de l'OCCGEAC, Yaoundé du 7 au 11 Décembre 1965*, Tome I, 9.

<sup>346</sup> SHD, *Rapport Final de la Première Conférence Technique de l'OCCGEAC, Yaoundé du 7 au 11 Décembre 1965*, Tome II, p. 363. ‘Nous ne voulons pas du tout faire renaître l'ex-SGHMP, et chacun peut me croire. Nous ne voulons pas non plus intervenir directement dans votre cuisine intérieure, et si nous préconisons certaines réformes, inspirées de ce qui se passe dans certains Etats ou certaines méthodes sont apparues mieux adaptées, c'est dans le désir de toujours voir s'améliorer les SGE. »

approaches and agendas of the African leaders involved should not be disregarded. The impetus for Cameroon to play such a large role in OCEAC's creation and functioning provides a significant and illustrative example.

### **Cameroon as Headquarters**

Attendees of the conference in 1963 to create OCEAC chose, with reported unanimity, the capital city of Cameroon, Yaoundé, as the headquarters of the organization, based on the idea that Cameroon was the sole member state to share borders with the four other members, which would facilitate communication.<sup>347</sup> This decision, represented as a simple, logical and straightforward one in the institutional historical record of the organization flattens the complexity of the significance of Cameroon's participation, and indeed its centrality, to the new regional health organization. In the discussion of the progression of coordination in the region in the final years of colonial administration, a slippage occurs between discussions of coordination between the four former territories of French Equatorial Africa in the late 1950s, to the inclusion of Cameroon in this grouping. This slippage obscured both the historical distinctness of Cameroon's health administrative structure, in particular the independence of its mobile health structure, throughout the period of French administration. As shown, public health officials in Cameroon in the 1950s cited the territory's distinct medical administration as a positive feature that allowed for greater efficiency. This difference from the colonial period should be recognized while not overstated: the health administrations of Cameroon and French Equatorial Africa still fell under the same umbrella of the French colonial health service. Similarly, the circuits traveled by French colonial administrators, and particularly medical

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<sup>347</sup> WHO. *Rapport Final de la Conférence des Ministres de la Santé des États Équatoriaux*. Yaoundé, les 21, 22, 23 août 1963, 16

personnel, were not hindered by this difference of status; the famous Dr. Jamot's work on sleeping sickness in Cameroon became a venerated and replicated model throughout the French empire in Africa. French doctors commonly worked throughout the various African territories over the course of their careers. Some African medical officials had similarly traveled cross-territorial paths of training and work, through training at the Dakar Medical School or in France. The shared medical history between French Cameroon and its neighbors mattered greatly for the creation of OCEAC. At the same time, Cameroon's distinct administrative status significantly shaped the broader politics of decolonization and independence in the territory and thus also drove its involvement in OCEAC in ways not fully revealed in the organization's self-narrative.

The difference of status created by the Mandate and Trusteeship system became a defining feature of Cameroonian politics both locally and internationally in the 1950s; the anti-colonial political party, the *Union des populations du Cameroun* (UPC), leveraged this status and petitioned the United Nations as part of their call for immediate independence from France, also taking up an armed struggle within the territory.<sup>348</sup> The French administration outlawed and violently fought against this movement, and helped to facilitate the ascension of power to political leaders in Cameroon amenable to an ongoing relationship with France. The early 1960s were, moreover, a time of continued conflict as the independent government worked, with significant support from the French military, to violently repress the ongoing armed opposition.<sup>349</sup> The independent state of Cameroon had also charted a different course than its

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<sup>348</sup> Meredith Terretta, "We Had Been Fooled into Thinking that the UN Watches over the Entire World": Human Rights, UN Trust Territories, and Africa's Decolonization." *Human Rights Quarterly* 34.2 (2012): 329-60.

<sup>349</sup> Cameroonian author, Mongo Beti, has argued that the extent of violence in this period was largely written out of history: Mongo Beti, *Main Basse sur le Cameroun: autopsie d'une décolonisation* (Paris: François Maspero, 1972).



neighbors in terms of the cementing of state political borders and national identity by the time of the creation of OCEAC. In 1963, when the health organization was founded, the Federal Republic of Cameroon had for two years been an officially bilingual English-French state, growing out of the 1961 referendum that led to the joining of the southern territory of the British Cameroons with the former French Cameroon.<sup>350</sup> The history of this distinct status during colonial administration and the circumstances of the Federal Republic created a complex set of factors surrounding the international relations of the independent state.

Medical officials crafted their own particular discourse about the necessity and purpose of their coordination through OCEAC, but these choices within the medical field largely adhered to the bottom-line international affairs agendas and regional policy of first Cameroonian President Ahidjo, while also exhibiting some important differences. Ahidjo's policy towards other African states in the early 1960s encompassed two paradoxical characteristics: first, an assertion of Cameroon's distinctness from other formerly French-administered territories and second, a practical turn towards diplomatic work with former French territories. On one hand, Ahidjo had actively avoided membership in the French Community and asserted Cameroon's distinct status from those African territories that were members.<sup>351</sup> While this stance grew from Cameroon's history as a United Nations Trusteeship, which meant that it had not participated in the 1958 referendum giving French colonies the choice to join the Community<sup>352</sup>, it also became re-enforced in the face of the ongoing political

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See also: Manuel Deltombe, Thomas Domergue, Jacob Tatsitasa, *Kamerun! Une guerre cachée aux origines de la Françafrique, 1948-1971* (Paris: La Découverte, 2011).

<sup>350</sup> See Chapter 3 on the implications of this arrangement for state public health administration.

<sup>351</sup> Torrent, 48-49.

<sup>352</sup> Torrent, 22.

opposition of the UPC<sup>353</sup>, and as French Cameroon joined with the southern British Cameroon to form the Federal Republic. As part of the blueprint for unification of the territories, leaders had pledged in 1960 to represent the commitment of the new state to bilingualism by foregoing membership in either the French Community or the British Commonwealth.<sup>354</sup> That said, the trajectory of independence and the creation of the Federal Republic, with French Cameroon first becoming independent in 1960 and then joining with the southern British Cameroon territory in 1961, facilitated the initial diplomatic stances that Ahidjo took before unification as remaining the policy afterwards.<sup>355</sup> In 1960, Ahidjo had indeed focused diplomacy on Francophone African states, contributing, for example, to the creation of the *Union Africaine et Malagache* (UAM) in 1960.<sup>356</sup> Even as he moved forward with coordination through select French-African affiliations, however, Ahidjo maintained what historian Mélanie Torrent has characterized as “a distinct caution” vis-à-vis these bodies.<sup>357</sup>

Ahidjo appeared slightly less weary of Francophone association on a smaller regional scale. In 1960 he made clear his position that working closely with the states of former French Equatorial Africa might be a path towards regional unity, while he struck a less enthusiastic

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<sup>353</sup> Jean-François Bayart, ‘La Politique Extérieure du Cameroun (1960-1971),’ *Revue française d’études politique africaines*, 75 (1972), 48.

<sup>354</sup> Torrent, 3. Citing *The Two Alternatives* of 1960, outlining this commitment by Ahidjo and the Southern Cameroons Premier, John Ngu Foncha.

<sup>355</sup> Torrent, 81-82.

<sup>356</sup> Torrent, 82. The UAM grew out of a 1960 meeting of representatives from Francophone African states who agreed to work towards creating common positions in international affairs. The countries represented included Cameroon, Ivory Coast, Congo (Brazzaville), Dahomey, Upper Volta, Mauritania, Niger, Senegal, Gabon, Central African Republic and Chad.

<sup>357</sup> Torrent, 159.

note about the more grand discourses of the time about a continental African unity.<sup>358</sup> In 1961 Cameroon joined the Equatorial Customs Union, first created by the former territories of French Equatorial Africa in 1959.<sup>359</sup> Chad and the Central African Republic would benefit from this affiliation through the avenue to coastal access through Cameroon, as would all of the states due to Cameroon's "relative demographic, economic and military power."<sup>360</sup> After many decades of Cameroonians insisting on their distinctness from AEF due to their divergent colonial history, the French Ambassador to Cameroon in 1963 characterized this turn by Cameroon towards the former states of AEF as a strategic economic one.<sup>361</sup> This cooperation with the former AEF states remained limited to certain spheres, however, with Ahidjo rejecting in 1961 the idea of joining a military Defense Council formed by the AEF states.<sup>362</sup> Ahidjo moreover displayed an aversion to working with inter-state organizations headquartered in Brazzaville, which seemed to indicate a folding of Cameroon into a former model of AEF governance.<sup>363</sup> Ahidjo thus pursued this scale of regional cooperation in a Francophone framework through certain avenues, while remaining active yet more reserved towards the creation of larger groupings.

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<sup>358</sup> Torrent, 49-50.

<sup>359</sup> Mélanie Torrent, *Diplomacy and Nation-Building in Africa: Franco-British Relations and Cameroon at the End of Empire* (New York: Palgrave Macmillan, 2012), 81. In 1964 the union formalized itself as the *Union Douanière et Economique d'Afrique Centrale* (UDEAC).

<sup>360</sup> Jean-François Bayart, "La Politique Extérieure du Cameroun (1960-1971)," *Revue française d'étude politique africaines*, 75 (1972), 58.

<sup>361</sup> CADN 743PO/2/3, Jean-Pierre Benard, Ambassadeur de France au Cameroun à Monsieur le Ministre des Affaires Etrangères Direction des Affaires Africaine et Malgaches, Yaoundé le 27 Février 1963. The ambassador noted the benefit of working as a group of states in the face of the powerful neighbors of Nigeria and Congo (Léopoldville).

<sup>362</sup> CADN 743PO/2/3, Jean-Pierre Benard, Ambassadeur de France au Cameroun à Monsieur le Ministre des Affaires Etrangères Direction des Affaires Africaine et Malgaches, Yaoundé le 27 Février 1963.

<sup>363</sup> CADN 743PO/2/3, Jean-Pierre Benard, Ambassadeur de France au Cameroun à Monsieur le Ministre des Affaires Etrangères Direction des Affaires Africaine et Malgaches, Yaoundé le 27 Février 1963.

The Cameroonian doctors involved in OCEAC's creation and early work, particularly Dr. Simon Pierre Tchoungui and Dr. Jean-Claude Happi, championed this vision of regionalism through the lens of health work while also asserting and representing Cameroon's centrality to it. Unlike Ahidjo, the Cameroonian leaders of OCEAC did not at all emphasize Cameroon's distinctness in either a historical or contemporary sense in the context of the organization. On the contrary, they rather advanced the idea that what mattered most in the relationship between the member states were the historical connections of the French colonial health service, of the mobile health teams and of the great 'founding father,' Jamot.<sup>364</sup> Moreover, while in the 1950s French medical officials had expressed such concern for the integrity of the mobile health service across the colonial federations, now Cameroonian doctors, their counterparts in the four other member states of OCEAC, and French doctors together drew on this prior geographic vision while also expanding it to include Cameroon. The material benefit of Cameroon's place in OCEAC to the other states is clear from the breakdown of the each state's contribution to the organization's budget. For Cameroon, the organization solidified its position as a powerful center of public health work in the region.

The Cameroonian leaders of OCEAC chose to present Cameroon in this grouping through the emphasis on this shared past, rather than through the additional complexity of a legacy of British colonial administration *within* the country. Orienting internationally towards Francophone medical affiliations bolstered the force of the mobile health teams and other aspects of the French colonial medical system as the blueprint for the public health system of the independent Federal Republic. Through their national and regional leadership roles, these Cameroonian doctors advanced the simultaneous processes of making Cameroon's entire

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<sup>364</sup>Lachenal (2009), 422.

national public health administration run on the French model, supporting contemporary roles for French doctors in health institutions, and crafting an international relations of health focused on francophone African states. The viability of Cameroon's position as OCEAC's headquarters thus depended both on the external politics of public health affiliation with other Francophone African states and on an internal state process of centralization of the national medical administration around the French model, which included the extension of mobile health teams and French medical personnel to Anglophone West Cameroon (discussed in Chapter 3). Tchoungui and Happi's advancement of OCEAC thus promoted the definition of the public health administration along the French model in independent Cameroon through its inclusion in the region.

### **OCEAC as a Health Region**

In addition to a discourse that emphasized Cameroon's shared colonial medical history with the former AEF, however, African health ministers also advanced a view of the organization's member states as naturally tied together through both geography and through post-independence political imperatives. In a 1968 ministerial conference of the organization, for example, Dr. Happi argued that the goal of health coordination between the states was facilitated by this geographic unity:

And this was somewhat facilitated because our five member states present the same pathology due to a similar geography, the fact that the south of three of our states is a forest region whereas the north of these states, and Chad, are savannah and even sahelian regions. It's certain that this geographic unity supports a pathological unity, as none of our states are separated from his neighbor by borders naturally difficult to cross, but by administrative borders, they have never mounted a barrier to microbes, viruses, parasites, insects who have spread across our countries a pathology particularly rich and particularly deadly. The goal of OCEAC has principally been to knock down these virtual borders, to disregard political

divergences that are often passing, to come to a true and effective fight against the causes of illness and their vectors.<sup>365</sup>

In this instance, Happi cast OCEAC's unity not through terms of medical infrastructure but through landscape, and he essentially argued that all political arrangements were but a fleeting imposition on a fundamental ecological truth. This statement was not inaccurate as much as it was selective, by defining the parameters of this ecology purely through the boundaries of OCEAC states. As will be further explained in Chapter 4, the Cameroonian border with Nigeria presented one of the most significant in terms of the control of disease across political borders. By carving themselves out as a group both through positive affirmation of their own internal cooperation, OCEAC thus designated space beyond their borders as a source of possible disease threat. Nigeria fell outside of this grouping and was thus identified by public health officials as a potential source for 'imported' diseases.

At the same time, Health Ministers also cast OCEAC as a part of a future-looking regional integration, as a unity that was being actively built. Dr. Jacques Bouiti of Congo, for example, characterized Central Africa as:

...an entity, a region that is building itself slowly but surely. OCEAC is living proof of this human solidarity, an effective and active solidarity...Political authorities of the five sister republics have long grasped this mission, thus realizing that their role is not only to reconcile and protect the inviolable rights of their citizens, but also to share with the other states of Central Africa their projects, their resources, to achieve objectives that would otherwise be inaccessible to them.<sup>366</sup>

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<sup>365</sup> SHD. *Rapport Final de la Quatrième Conférence Ministérielle Inter-Etats de l'OCEAC, Bangui Les 28 et 29 Octobre 1968*, 8.

<sup>366</sup> SHD 619, *Rapport Final de la Quatrième Conférence Ministérielle Inter-Etats de l'OCEAC, Bangui les 28 et 29 Octobre 1968*, 77-78.

From a political standpoint, the ministers of OCEAC also argued that without the organization, they would not be able achieve this level of coordination and would also not be able to obtain comparable levels of external assistance.<sup>367</sup> Health officials connected to OCEAC thus justified its existence and argued for its coherence through a variety of different framings. In all of their celebrations of OCEAC's work, however, they constructed the idea that the member states' collaboration constituted something at once inevitable and of great political importance. And it was through all of these historical, ecological and political arguments that OCEAC officials asserted the idea of their grouping as an entity that both reflected and advanced the fundamental concerns of public health.

### **OCEAC at work**

In the late 1960s, the work of OCEAC would develop through the headquarters of the Secretary General in Yaoundé, as well as through yearly ministerial and technical conferences. The organization took on a variety of tasks falling under the general rubrics of coordination, research and training. This work included the collection and analysis of statistics on communicable diseases and vaccination rates across the states. It provided technical direction on the launching and coordination of vaccination campaigns and oversaw the provision of common medical materials to the states. In the realm of research, OCEAC collaborated with other institutions such as the Pasteur Institute in Cameroon and the American Centers for Disease Control and conducted some small scale research on vaccination associations. In the realm of education, OCEAC developed a training program in Yaoundé for health personnel working with the mobile health teams. Finally, OCEAC accepted and coordinated regional-level

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<sup>367</sup> SHD. *Rapport Final de la Quatrième Conférence Ministérielle Inter-Etats de l'OCEAC, Bangui Les 28 et 29 Octobre 1968*, 6. Comments by the Minister of Health for the Central African Republic, Alexandre Banza.

international aid to the member states and sent representatives to international health conferences.<sup>368</sup> This was one of the key ways that OCEAC preserved a role for French doctors as brokers of coordination between African states and with international health bodies. René Labusquière and his French deputy, for example, often traveled to international health conferences in their capacity as the leadership of OCEAC, thus creating the paradox of having a French man representing an inter-state organization of independent African countries.<sup>369</sup>

OCEAC meetings also themselves became a forum of discussion with international health organizations. When OCEAC held its first technical conference in December of 1965, representatives from the American Centers for Disease Control and the World Health Organization attended to discuss the implementation of a regional program for smallpox eradication, as part of the larger program for global eradication of the disease. OCEAC would play a defining role in the framing and local implementation of this program, thus cementing its position as a regional broker of international health programs (see Chapter 4).

By investing in OCEAC, African health officials and French military doctors transformed a regional conception of the governance of colonial medicine into a postcolonial health region of significance for international health. They made a statement about what kinds of health infrastructure were internally generated, already on the ground, and shared between certain independent African countries. OCEAC at the same time presented itself as being in line with trends towards more geographically expansive, cross-border visions of public health,

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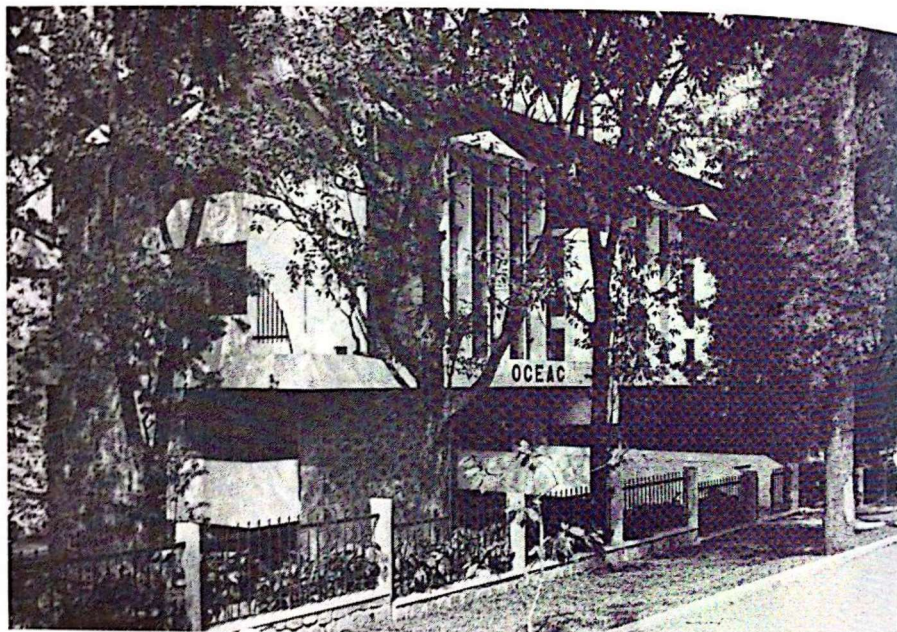
<sup>368</sup> SHD 2013 ZK 005 614, *L'Organisation de Coordination pour la Lutte contre les Endemies en Afrique Centrale*, Plaquette réalisé et éditée par le Secrétariat Général de l'OCEAC à l'occasion de la première Conférence Technique, OCCGE-OCEAC (Paris 2-6 mai 1972), Imprimerie Coulouma : Yaoundé, 8.

<sup>369</sup> SHD 2013 ZK 005 619, *Rapport Final de la Quatrième Conférence Ministérielle Inter-Etats de l'OCEAC, Bangui les 28 et 29 Octobre 1968*, 65-66.



represented by the WHO and the focus on disease eradication at this time. Creators of the organization claimed that their ‘borderless’ work grew naturally and internally from the history of mobile health teams and the political affiliations of African states, rather than externally from the agendas of international health organizations.

Through both its creation and its work in the 1960s, OCEAC thus staked an important claim on the functioning of international health coordination in Cameroon and other states. While defining itself explicitly against the regional model for Africa proposed by the World Health Organization, OCEAC officials asserted that the most efficient avenue to public health coordination beyond the national scale would be through the smaller scale of the region it encompassed. Rooted in a purportedly successful and coherent medical past while claiming a role in a progressive, international, public health future, OCEAC created its region as a resource and thus insisted upon a position of authority in the evolving field of international health in Africa.



YAOUNDE. — Le Siège du Secrétariat Général

OCEAC headquarters in Yaoundé. SHD 2013 ZK 005 614, *L'Organisation de Coordination pour la Lutte contre les Endémies en Afrique Centrale, Plaquette réalisé et éditée par le Secrétariat Général de l'OCEAC à l'occasion de la première Conférence Technique, OCCGE-OCEAC (Paris 2-6 mai 1972) Imprimerie Coulouma : Yaoundé.*



Dr. Jean-Claude Happi at Third Technical Conference of OCEAC, 1968. SHD 2013 ZK 005 619, *Rapport Final de la Troisième Conférence Technique de l'O.C.E.A.C.*, Yaoundé du 24 au 27 Janvier 1968, Tome 1.

### Chapter 3: Bilingual medicine in the Franco-African state

In 1965, groups of Cameroonians began marching to the office of the Director of Medical Services in the coastal city of Victoria (now Limbe)<sup>370</sup> to protest conditions of the medical services across the state of West Cameroon and in the city hospital. Four years after the unification of part of the former British Cameroons and the former French Cameroon into a Federal Republic, Cameroonians in the anglophone federated state particularly emphasized their dismay over the work of French doctors sent to the region and their inability to communicate with the population. On October 20<sup>th</sup> a delegation of chiefs and elders led by a member of the West Cameroon House of Assembly, R.N. Namme, marched to the Director's office and presented a signed petition. They wrote, "We the chiefs and people of Victoria have come to you as the Commissioner General of Health's delegate to protest over the deteriorating services in the General Hospital of Victoria. We say deteriorating because frankly speaking patients had better Medical attention in the pre-independence years." Their list of grievances was long and included shortages of drugs and the discontinuation of hospital meals for "paupers and patients with infectious diseases." They also highlighted one problem that reflected a very particular challenge of medicine in independent Cameroon:

We must emphasize that 99% of the people in Victoria speak only English and therefore any doctor to be posted to Victoria must be able to speak and consult in English, be he a French Aid or World Health Organization Doctor....We strongly protest against the present trend of affairs and this delegation is a spontaneous reaction of how bitter we feel. We know that our post independent government is our own government. Yet if it is our own government we have a right to advice and to register our concern when a bungle of the Medical Services is brewing. We expect a better service than before and not to be given serpents (sic) when we require bread. For

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<sup>370</sup> The city name was changed to Limbe, its current name, in 1982. Mark W. DeLancey and H. Mbella Mokeba. *Historical Dictionary of the Republic of Cameroon*, 2<sup>nd</sup> edition (Metuchen, NJ & London: The Scarecrow Press, Inc, 1990), 122.

your immediate attention, we require more doctors should be English speaking and more drugs and equipment.<sup>371</sup>

These tensions and the demands by people living in Victoria illustrate a new dimension of the politics of public health and medicine that developed in 1960s Cameroon in the wake of the creation of an officially bilingual federal republic, constituted by the francophone state of East Cameroon and the anglophone state of West Cameroon. Histories of health and medicine in Cameroon have given little attention to the implications of this political arrangement, and works on state biomedicine have instead largely examined the trajectory of Cameroonian medical history in light of the relationship to France.<sup>372</sup> We see a similar trend in the place accorded to Cameroon in histories of international health, such as institutional histories of the global smallpox eradication program of the 1960s, with Cameroon being described exclusively as a former French colony and part of the bloc of francophone African states.<sup>373</sup> Chapters 2 and 4 of this dissertation delve into closer analysis of the political and operational significance of these characterizations, but this chapter looks more closely at internal dynamics of Cameroonian medical services in relation to its unique regional circumstance of bringing together a former French and former British territory into an independent African state.

The protests over French doctors working in West Cameroon who could not communicate with their patients highlights a broader tension over the parameters of a

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<sup>371</sup> National Archives of Cameroon, Buea. Sc/a 1962/7, *Services de Santé au Cameroun Occidental*, petition dated 20<sup>th</sup> October 1965.

<sup>372</sup> Guillaume Lachenal, 'Franco-African Familiarities: A history of the Pasteur Institute of Cameroon, 1945-2000,' In *Hospitals beyond the West: from Western Medicine to Global Medicine*, edited by Mark Harrison and Belinda White, 411-444 (Orient Longman: New Delhi, 2009). Luc Serge Fongang, 'L'évolution des politiques sanitaires au Cameroun (1920-2000),' In *Le Pluralisme Médical en Afrique: Colloque International de Yaoundé, 3-5 Février 2010 Hommage à Eric de Rosny*, directed by Ludovic Lado, 133-152 (Paris: Karthala; Yaoundé: Presses de l'UCAC, 2011).

<sup>373</sup> Horace Ogden, *CDC and the Smallpox Crusade* (Atlanta, GA: U.S. Dept of Health and Human Services, Public Health Service, Centers for Disease Control, 1987).

Cameroonian public purportedly served by national public health and medical services after independence. The drive from the Ministry of Health in Yaoundé to merely extend the medical structures and personnel of francophone East Cameroon to West Cameroon proved problematic and became a source of debate over the course of the 1960s. Moreover, France's efforts to extend its influence from East to West Cameroon via medicine raised questions about the role of the former colonial power across the Federal Republic.

The specific push by East Cameroonian and French health officials to extend the mobile health system to West Cameroon embodied these tensions and represented a central aspect of debate about public health administration in the new nation. As discussed in the previous chapters, the mobile health service, created by French military doctors during colonial administration, remained the absolute hallmark of French colonial medicine for generations of French doctors and francophone Cameroonian medical personnel. After independence, French military doctors continued to dominate the administration of the mobile health service in Cameroon through the framework of 'technical assistance' provided by the former colonial power. This arrangement had far-reaching implications, as East Cameroonian health officials asserted the mobile teams as foundational to independent Cameroon's politics of national, regional, and international health work. As discussed in chapter 2, Cameroon became the headquarters for a regional health organization that championed the mobile health team model as the basis for public health coordination between neighboring African states that had been French colonies.<sup>374</sup> The focus on sustaining and growing mobile health teams after

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<sup>374</sup> As shown in chapter 2, Cameroon became in 1963 the headquarters for a new regional health organization, *l'Organisation de Coordination et de Coopération pour la lutte contre les Grandes Endémies en Afrique Centrale*. The organization, with joint leadership between a French military doctor and the Minister of Public Health of Cameroon, coordinated the work of mobile health teams between Cameroon and the four states of former French Equatorial Africa (Central African Republic, Chad, Congo-Brazzaville, and Gabon).

independence thereby greatly shaped how Cameroon engaged with other African states and subsequently how it engaged with international organizations on health programs during the formative decade of the 1960s.

The push from the federal Ministry of Health to extend the mobile health team system to West Cameroon was therefore emblematic of developments within Cameroon that ultimately shaped the country's external dealings on public health. The plans to extend the teams represented the centralization of Cameroonian health policy around Yaoundé, the dominance of French-created institutions, and the privileging of ongoing ties to France in the field of medicine. But rather than frame these developments exclusively through the lens of the French-Cameroonian relationship, this chapter grounds their negotiation in the vantage point of medical administration in West Cameroon and thus highlights the formation of a set of concerns about medicine distinctly rooted in the politics of post-colonial Cameroon. This chapter places the extension of the mobile health teams in the context of broader debates about the future of medical administration in the country.

The debates among Cameroonians surrounding the integration of medical infrastructures in the two federated states, growing from two different colonial legacies, merits examination for at least three reasons. First, Cameroonian doctors, as well as other citizens, created a discourse highlighting the differences of medical practice and infrastructure along the fault lines of these colonial legacies to make arguments about what needed to be done in the field of public health planning for the independent state. Looking specifically at which elements of the two systems Cameroonians defended and critiqued provides a window into the development of health policy and medical culture in the 1960s within Cameroon, while also pointing to dynamics that developed surrounding medical coordination more broadly between former British and French

colonies in West and Central Africa. Second, while the ongoing presence of French doctors in francophone East Cameroon exemplified the close ties maintained between France and former African colonies after independence, the post-independence presence of French doctors in anglophone Cameroon raised entirely different questions about the meaning and the limits of these ties for the new bilingual nation. The work of the French doctors in West Cameroon points to rather ambiguous parameters of national versus international public health in 1960s Cameroon. Finally, these debates over what the federal system meant in the context of medicine merit attention *because* Cameroonian public health officials so firmly entrenched the country in francophone medical networks in the 1960s, presenting the state on these terms in the context of international health organizations and campaigns. A closer look at the dynamics between West and East Cameroon surrounding public health administration complicate the idea of a history of cooperative continuation of French-Cameroonian medical networks after independence. Examining the questions Cameroonians raised in the 1960s about the nature of medical policy in the new nation therefore ultimately highlights an active negotiation over what constituted external versus internal influence, insight, and decision-making power over the administration of public health and medicine in the wake of decolonization.

### **Public Health and the Federal System**

The creation and then dissolution in 1972 of the Cameroonian federal system remains a politically charged and debated topic in the country to this day, related in large part to continuing political tensions over the anglophone/francophone divide in the country. At the height of these tensions, anglophone Cameroonians have at times called for secession and the

formation of their own country.<sup>375</sup> The complexity of this much longer history, while beyond the scope of this study, serves as essential context.<sup>376</sup> The broader question of relationships of national administration, institutions, and cultures across the two areas is a pertinent contemporary as well as historical topic, but this chapter will focus on the preliminary discussions about the integration of public health and medical services in the 1960s.

The Federal Republic of Cameroon came into being on October 1, 1961 and comprised the territorial boundaries of Cameroon that are still in existence today. The independent country grew out of what was formerly French Cameroon, a United Nations Trusteeship under French administration until 1960, and the former British Southern Cameroons, also a former United Nations Trusteeship until 1961.<sup>377</sup> The entirety of the British Cameroons United Nations Trusteeship included a Northern and a Southern Territory on the western border of French Cameroon, and the British essentially administered the territories as part of Nigeria. In a February 1961 UN-run plebiscite, people living in each of the British Cameroons voted separately on whether to become independent by joining with either Nigeria or the newly

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<sup>375</sup> The federal republic was created in 1961 and dissolved to create the United Republic of Cameroon following a referendum in 1972. On the politics of this divide see: Verkijika G. Fanson, "Anglophone and Francophone Nationalisms in Cameroon," *Round Table* 350 (April 1999): 281-296. Piet Konings and Francis B. Nyamnjoh. "The Anglophone Problem in Cameroon," *The Journal of Modern African Studies* Vol. 35 No. 2 (June 1997): 207. Konings and Nyamnjoh date a hardening of positions and articulation of the existence of an 'anglophone problem' in Cameroon to the early 1990s, a period of political liberalization, and the contested presidential elections of 1992.

<sup>376</sup> Notably, the contemporary political context of this issue clearly informed comments made in some of the oral history interviews I conducted in Cameroon. For example, one person I spoke with in Cameroon insisted that as soon as the Federal Republic was created, there was no sense of divide between the British and French medical systems in Cameroon. My archival research and other interviews suggest otherwise. Moreover, this interviewee had a large picture of Cameroonian President Paul Biya hanging in the living room, suggesting support for the ruling political party which has sought to downplay the volatile "anglophone problem."

<sup>377</sup> The entire territory was first a German protectorate from 1884 to 1916, known as Kamerun, the German spelling. The territory was divided after WWI and made into League of Nations Mandates under British and French administration. With the end of the League of Nations and of WWII, the Cameroons became 'Trust territories' of the United Nations, still under British and French administration.

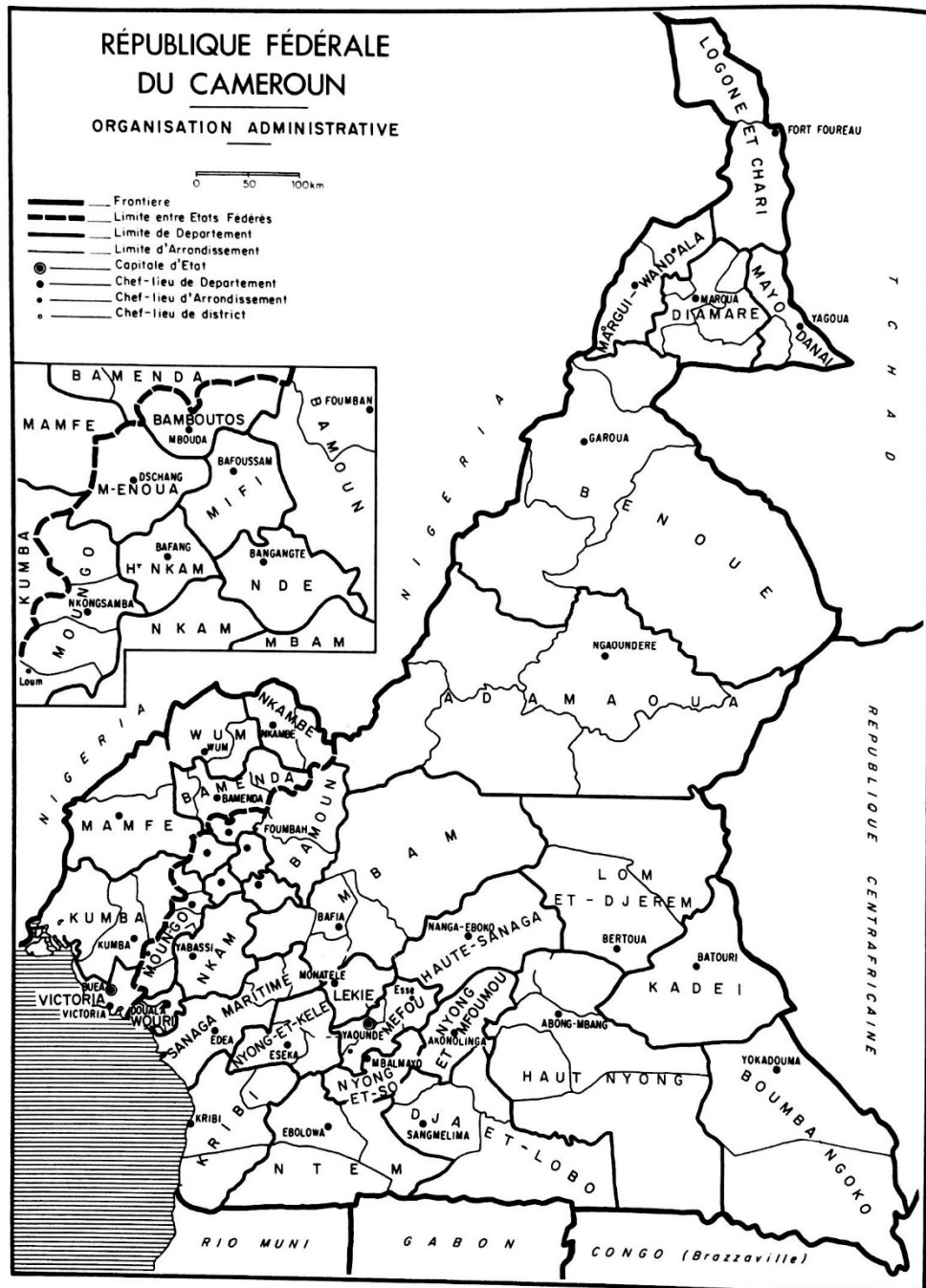


independent *République du Cameroun* to the east.<sup>378</sup> The British Northern Cameroons voted to become part of Nigeria and the Southern Cameroons voted to join with the *République du Cameroun*. Delegates from the two territories of the new Cameroon met at the Foumban conference of July 1961 to create a constitution and framework for the state. The resulting system for the Federal Republic of Cameroon created two states-West Cameroon, the former British Southern Cameroons, and East Cameroon, the former French territory. Cameroonians established the Federal Republic as officially bilingual, with both French and English as official languages. At the time of the creation of the federation, the population of West Cameroon constituted about twenty percent of the total population of Cameroon and the state territory comprised about nine percent of the total national territory.<sup>379</sup> Each state had its own government with a Prime Minister, and the federal administrative structure was headed by a President and Vice-President. The delineation of federal and state responsibilities evolved over the course of the 1960s, but the entire system came to an end in 1972 with the dismantlement of the federal system and the creation of a unitary state. The politics of the Federal Republic were thus both fleeting and enduring in that the political and administrative structures of the 1960s changed abruptly, but they also created and left a complicated legacy.

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<sup>378</sup> The French-administered territory of Cameroon had become independent on January 1, 1960.

<sup>379</sup> Willard R. Johnson, *The Cameroon Federation: Political Integration in a Fragmentary Society* (Princeton, NJ: Princeton University Press, 1970), ix.



Source: Federal Government, Republic of Cameroon

Willard R Johnson, *The Cameroon Federation: Political Integration in a Fragmentary Society* (Princeton, New Jersey: Princeton University Press, 1970), 2.

With the creation of the federal system in 1961, questions about the coordination of a host of administrative issues between the states, such as currencies, trade, and transportation, arose quickly.<sup>380</sup> Cameroonian political elites created a system that preserved some separate governmental representation and administrative functions for the East and West states while centralizing certain aspects, such as foreign affairs, finance and justice, at the federal level.<sup>381</sup> Both contemporaries and retrospective observers have often argued that the dominance of East Cameroon over that of the Western state was inevitable, due both to the imbalance of geography and population between the two territories as well as the terms of the constitution adopted in 1961.<sup>382</sup> Delegates from West Cameroon sought a loosely associated federation, while the proposals advanced by the first president, Ahmadou Ahidjo, and other delegates from East Cameroon ultimately prevailed in the creation of a constitution allowing for increasing centralization of administration at the federal level and a strong presidency.<sup>383</sup> From 1961 to the end of the federation in 1972, President Ahidjo consolidated his own power through the creation of a singular national political party in 1966 and the increasing concentration of the administrative functions of the state through federal avenues.<sup>384</sup>

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<sup>380</sup> Victor LeVine, *The Cameroon Federal Republic* (Ithaca, New York: Cornell University Press, 1971), 34-35.

<sup>381</sup> Mélanie Torrent. *Diplomacy and Nation-Building in Africa: Franco-British Relations and Cameroon at the End of Empire* (London: I.B. Tauris & Co. Ltd, 2012), 69.

<sup>382</sup> LeVine, 94. On the outcomes of the Foumban conference developing the 1961 constitution, see Fanson, 1999, p. 291. See also Victor Julius Ngoh, "The Origins of the Marginalization of Former Southern Cameroonians (Anglophones), 1961-1966: An Historical Analysis," *Journal of Third World Studies* 16 (1999): 165-185. Chapter 8: Willard R. Johnson, *The Cameroon Federation: Political Integration in a Fragmentary Society* (Princeton, NJ: Princeton University Press, 1970).

<sup>383</sup> Johnson, 184-191.

<sup>384</sup> On the politics of this centralization and consolidation : Jean-François Bayart, *L'Etat au Cameroun*, (Paris: Presse de la Fondation Nationale des Sciences Politiques, 1984). Bayart has argued that the unification of West and East Cameroon did not impede, but rather bolstered, the argument for a need for a unified national party and national integration, 109. He also argues that Ahidjo knowingly played off political divisions among Anglophone elites in order to bring them in line with the unified party and centralize his own power, 116.

The general trajectory of public health administration in the 1960s also began with a degree of separate control by the federated states but moved increasingly towards a consolidated federal administration. Even as this consolidation progressed, the delineation between state and federal functions of health were far from being rigidly defined or protected. The constitution of 1961 set public health administration as a state function, but one that could be taken over eventually by federal authorities.<sup>385</sup> 1961 laws created the Federal Ministry of Public Health headed by a Minister and Deputy Minister, meant to assist the Minister with all concerns related to West Cameroon.<sup>386</sup> French-trained Dr. Simon-Pierre Tchoungui served as the first Minister of Public Health of the Federal Republic,<sup>387</sup> with Anglophone Augustine Ngom Jua as the first Deputy Minister.<sup>388</sup> This appointment created an imbalance of expertise, however, as Jua was not medically trained.<sup>389</sup> A Director of Medical Services based out of Victoria in West Cameroon and another based out of Yaoundé for East Cameroon were the highest state-level officials of each federated state and reported to the Federal Minister of Public Health.<sup>390</sup> West Cameroon was further divided into six divisions, each overseen by a Medical Officer, who

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<sup>385</sup> Johnson, 185. Public health was listed as a ‘second stage federal power’ under Article 6 of the 1961 constitution.

<sup>386</sup> NAC Decree no. 61/DF/22 of November 6, 1961. *Presse du Cameroun*, No. 3469, Mercredi 15 Novembre 1961, “Attributions des Ministres et Ministres Adjoints de la République Fédérale.”

<sup>387</sup> Named Minister by a decree of October 1, 1961. National Archives of Cameroon. *Presse du Cameroun*, No. 3449, Samedi 21 et 22 Octobre 1961.

<sup>388</sup> LeVine, 83.

<sup>389</sup> Jua had originally trained as a teacher before becoming a prominent political figure in the 1950s in the British Southern Cameroons. He later served as Prime Minister of West Cameroon beginning in 1966, but his efforts to protect the autonomy of West Cameroon led to conflicts with federal authorities. President Ahidjo replaced Jua as Prime Minister with Solomon Muna in 1968. DeLancey and Mokeba, 113.

<sup>390</sup> NAC Buea. James G. Roney, Jr. *Health and Medicine, Volume III of: The Economic Potential of West Cameroon—Priorities for Development*. Prepared for the Government of the Federal Republic of Cameroon and the Government of the Federated State of West Cameroon (Menlo Park, California: Stanford Research Institute, 1965), 17.

reported to both the Director of Medical Services and the Federal Ministry of Public Health. Internal state functions of West Cameroon were thus from the start defined by a somewhat ambiguous and uneven autonomy from the federal government. Initially, state and federal roles were divided along different realms of the public health and medical administration. State-level Directors oversaw hospitals and environmental health. The Federal level functions of public health included the Yaoundé-based head office for the *Service des Grandes Endémies et de Médecine Rurale*. This service oversaw the mobile health teams, but it did not truly extend into West Cameroon until the mid to late 1960s.<sup>391</sup> Despite the unevenness of internal state autonomy, the distinction between state and federal functions was ultimately more pronounced in West Cameroon than it was in East Cameroon in the first half of the 1960s due both to the distance from Yaoundé, the seat of federal services, and the historical differences of the health systems.<sup>392</sup>

Legislation in 1965 further consolidated public health administration at the federal level.<sup>393</sup> At this time, the Ministry of Health became the Office of the Commissioner-General of Health (CGH). A Federal Director of Health Services replaced the former positions of Director of Medical Services for both East and West Cameroon. The Director of Health Services in West Cameroon was instead named ‘Commissioner-General’s Delegate.’<sup>394</sup> The change, while semantic in nature, marked a move towards centralization through Yaoundé of the health

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<sup>391</sup> The functions of this Service were established through Decree no. 63/DF/143. *Journal Officiel de la République Fédérale du Cameroun*, 15 mai 1963, p. 369-370.

<sup>392</sup> Roney, 17.

<sup>393</sup> Decree no. 65-DF-238 of 4<sup>th</sup> June 1965 to organise the Office of the Commissioner General for Public Health and Population. *Journal Officiel de la République Fédérale du Cameroun*, 15 juin 1965, p. 603-606.

<sup>394</sup> NAC Buea. Sc/1959/2, G.G. Dibue, Director of Medical Services, Commissioner-General of Health’s Delegate “Annual Medical Report, West Cameroon, 1965,” April 23, 1966.

services. New legislation also further unified and centralized in Yaoundé the systems for preventive medicine, and for maternal and child welfare services.<sup>395</sup> As the new Federal Assembly in 1965 worked more broadly to harmonize institutions and services across the federated states, this year became a turning point by which the various branches of the medical services became in some way tied to federal oversight.<sup>396</sup>

Beginning with legislation in 1968 and through the dismantlement of the federal system in 1972, health policy also moved towards designating administrative health regions within the country that would be politically centered on the federal Office of the Commissioner-General of Health.<sup>397</sup> In this process, the CGH classified West Cameroon as one of the ‘health regions’ in the country, and thus indistinct from other designated ‘health regions’ of the country. In 1968, the country was first divided into four health regions, with a Chief Regional Medical Officer in charge of each area. The former office of the Director of Medical Services for West Cameroon, now called the Commissioner-General’s Delegate, would fill the role in the Anglophone state.<sup>398</sup> That role had thus transitioned from being a separate state authority to a delegate of the federal authority. By 1972, the CGH increased the number of health regions to seven, with

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<sup>395</sup> NAC Buea. Sc/1959/2, G.G. Dibue, Director of Medical Services, Commissioner-General of Health’s Delegate “Annual Medical Report, West Cameroon, 1965,” April 23, 1966.

<sup>395</sup> Ibid, 1-2.

<sup>396</sup> LeVine, 154.

<sup>397</sup> Interview with Dr. Thomas C. Nchinda, Founex, Switzerland, May 22, 2014. Dr. Nchinda characterized the health services as becoming more ‘regionalized’ after 1972, but we can also see the legislative origins of this development in 1968.

<sup>398</sup> Decree No. 68-DF-455 of the 27th November 1968. *Journal Officiel de la République Fédérale du Cameroun*. 1 Décembre 1968, 2129-2132. The four health regions were West Cameroon with headquarters in Victoria, the Littoral and the West headquarters in Douala, North headquarters in Garoua, and Centre-South and the East headquarters in Yaoundé. “In West Cameroon, the Delegate of the Commissioner General for Public Health and Population shall perform the functions of Chief Medical Officer of the health region.”

West Cameroon divided into two regions.<sup>399</sup> The health administration of West Cameroon thus became streamlined from a somewhat distinctly autonomous apparatus in the country to part of a regionalized national structure centered on Yaoundé.

Thus, while the federal legislative changes over the course of the 1960s advanced a subsuming of a distinct West Cameroonian medical system into national policy based on a French model, this outcome obscures the uneven and contested trajectory of this development. Throughout these legislative and administrative changes in the 1960s, West Cameroonian medical personnel, political officials and citizens pushed back against many of these changes and expressed interests in preserving a distinct administration of health services in West Cameroon. The remainder of this chapter considers how both East and West Cameroonians navigated these circumstances through questions of national standardization, in the case of the mobile health teams, as well as through questions of language, professional relationships and patient care. As East and West Cameroonians framed the differences, needs, and possibilities of medical structures between East and West Cameroon, they made commentary about their respective colonial histories but also about how they hoped to protect and advance their own stake in these systems.

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<sup>399</sup> National Archives of Cameroon, Yaoundé. *L'Agence Camerounaise de Presse*, no. 213 Mercredi 20 Septembre 1972, "Organisation du Ministère de la Santé et de l'Assistance Publique," 1-23.

West Cameroon was now divided into North-West with headquarters in Bamenda and Southwest with headquarters in Buea. The other 'province sanitaire' were Centre-South with headquarter in Yaoundé, East with headquarter in Bertoua, Littoral with headquarter in Douala, West with headquarter in Bafoussam, and North with headquarters in Garoua. In 1972, the health services was now called the Ministry of Health and Public Assistance or le *Ministère de la Santé et de l'Assistance Publique*.

## **“Two Civilizations”: Defining a Divide**

In the early 1960s, Cameroonian political officials often characterized the challenges of building a new nation as rooted in the legacy of dual colonial rule. Other questions of regional difference within the country certainly played an important role in the politics of this time, notably that of the largely Fulani area of northern Cameroon and the western Grassfields region of the Bamiléké, but the difference of institutions, language, and history between the two states of the federation led to a particular discourse about the gap between them and the need to bridge it. After the talks that led to the creation of the Federal Republic constitution in 1961, Prime Minister of West Cameroon and Vice President of the Federal Republic, John Ngu Foncha gave a statement characterizing the young country by the “existence of two Cameroon cultures,” hoping that one day a unified “indigenous one” would take their places.<sup>400</sup> While maintaining a critical perspective on the way this discourse assumed a certain totalizing force of colonial administration and legacy on Cameroonian lives and flattens other, and perhaps deeper, forms of regional or ethnic identification, the ways in which Cameroonians formulated and leveraged language about the nature and importance of this division is essential for understanding the country’s post-independence trajectory.

From the early 1960s onward the anglophone/francophone distinction became significant within Cameroonian society as something that designated linguistic difference, but

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<sup>400</sup> LeVine, 152. LeVine conducted research in Cameroon while the Federal Republic still existed. He wrote in 1971, “Apart from the question whether two such cultures actually existed, it is probably fair to say that ten years after unification Foncha’s ‘indigenous’ Pan-Cameroonian culture had only barely begun to take shape. The differences between the two states may only have been skin deep—or ‘colonial deep,’ as someone suggested in 1965—but these were societies on both sides of the common border between East and West Cameroon. What was involved in this union....were not only differences in language, culture, and institutions, but perhaps more crucial for the union, differences in political habit, and perceptions of authority crystallized during seventy-five years of separate colonial experience.” {sic} Note: the entire territory was administered together under German rule from 1884 to 1916, before being split into League of Nations Mandates under British and French administration.



also differences in political and cultural life. These differences were rooted in experiences of the educational opportunities, institutions and political systems created under British and French colonial administration. Cameroonian historian Verkijika Fanzo has also noted the important differences in how nationalism developed in the two territories, marked in part by different regional orientations, with the British Cameroons heavily influenced by the relationship to Nigeria.<sup>401</sup> After independence and the creation of the Federal Republic, the significance of this divide surely took on different dimensions and meaning for different kinds of people in Cameroonian society, such as those concerned with the impact of market trade, education, or law.

In the same vein, Cameroonians drew specific divisions in discourse about state-run public health and medicine. In a 1965 meeting of public health officials concerning the future of education for health personnel in Cameroon, the Commissioner General for Public Health and Population, Dr. Jean-Claude Happi, talked about the need to find a synthesis between the “two civilizations” in Cameroon, francophone and anglophone, that worked both for the Cameroonian system, while still responding to the norms of modern medicine.<sup>402</sup> The idea of two “civilizations” in the realm of medicine and public health spoke directly to differences in medical training and medical administration between the former British and French in territories. Whereas West Cameroonian medical personnel had trained primarily in Nigeria and England, East Cameroonians had trained in French Cameroon, Senegal, and France.<sup>403</sup> In

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<sup>401</sup> Fanzo (1999).

<sup>402</sup> NAC. *Agence Camerounaise de Presse* No. 139 du Mardi 22 juin 1965. “Hier à Yaoundé: Importante Réunion de la Santé Publique,” p. 1-2. Note: Chapter 5 provides more information on efforts towards bilingual medical education in Cameroon.

<sup>403</sup> The Yaba Medical Training College in Nigeria opened in 1930 to train medical assistants. In 1940, the course offered extended by one year and students could train as Assistant Medical Officers. In 1948, this school was

addition to training in different languages and educational systems, East and West Cameroonians also had experiences working in different medical systems.

Cameroonians trained in each system in many instances proudly protected the different inherited infrastructures of their respective state systems. The most prominent French-speaking Cameroonians in the public health administration in the 1960s, for example, championed the legacy of French colonial medical administration and drew a stark contrast with that which had been done in West Cameroon under British administration. In 1964 then Minister of Public Health, Dr. Simon-Pierre Tchoungui, who had trained in Senegal and in France, wrote about the organization of health services in Cameroon and highlighted not only the superiority of the health structure in East Cameroon over that of West, but also highlighted the sophistication of East Cameroonian medical systems in relation to other former French African colonies. He characterized Cameroon at independence as one of the most “privileged” countries among the former colonies in terms of health equipment.<sup>404</sup> By contrast, he wrote that the territory that comprised West Cameroon, while being administered as part of colonial Nigeria, had been relatively neglected in comparison to the other Nigerian provinces in terms of health equipment. He noted the ‘surprise’ in discovering after independence the point to which the health infrastructure in West Cameroon was underdeveloped in comparison to East Cameroon.<sup>405</sup> Dr. Tchoungui placed the two territories both in relation to each other as well as in a comparative

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moved and expanded to create the University College Hospital in Ibadan. The University offered medical degrees in standardization with the University Colleges of London University. Ibadan also began offering nurse training. Ralph Schram, *A History of the Nigerian Health Services* (Ibadan: Ibadan University Press, 1971), 204, 263, 274. In 1950 a nursing school was also created in Victoria, current day Limbe. Ndam, 2003, 59.

<sup>404</sup> NAC Buea. Sc/a 1964/14 *Organisation Générale des Services de Ministre de la Santé Publique et de la République Fédérale du Cameroun, par le Docteur S.P. Tchoungui, Ministre de la Santé Publique 1964.*

<sup>405</sup> Ibid, 6-7.

regional context to further emphasize the disparity between the two. In his estimation, East Cameroon shone even in comparison to the rest of the former French empire in Africa, while West Cameroon had been but a neglected region of Nigeria.

Tchoungui considered the mobile health service as absolutely central to the strengths of the medical system in French Cameroon. He most pointedly connected the ‘privilege’ of French Cameroon to the creation of the mobile health team service in the territory under the famous Dr. Eugène Jamot. Outlining the medical system under colonial administration, he noted, “We had... {in addition to the institutions of curative medicine}.. a mobile medical service that is still one of the best equipped because it was the first created in Africa.”<sup>406</sup> He thus cast the mobile health service, the pride and joy of the French-Cameroonian medical world, as making the territory exceptional in vast geographic and imperial terms.

Likewise, one of the most serious differences that Dr. Tchoungui noted between West and East Cameroon was that of the mobile health system. After listing other deficiencies he saw in the West Cameroonian medical system, he wrote:

But more seriously, there does not exist a mobile medical service directed by a doctor; one could thus reckon that, in the wake of reunification, the immense majority of the population does not benefit from medical care.<sup>407</sup>

The premise of the French mobile health service was going from village to village, diagnosing and treating patients and thus expanding medical care far beyond the confines of hospitals or even rural dispensaries. Tchoungui thus characterized the lack of this system as a major gap in the reach of the medical system in West Cameroon. West Cameroon did, in fact, in the early

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<sup>406</sup> Ibid, 4.

<sup>407</sup> NAC Buea. Sc/a 1964/14 *Organisation Générale des Services de Ministère de la Santé Publique et de la République Fédérale du Cameroun, par le Docteur S.P. Tchoungui, Ministre de la Santé Publique 1964*, 8.

1960s have its own system of itinerant nurses and medical personnel, which will be discussed more fully later in the chapter. The characterization, however, of the impact of the French mobile health service versus that which existed in West Cameroon invested the discourse of difference in medical culture between West and East Cameroon with both the weight of colonial history and the stakes of contemporary care for Cameroonians across the new nation.

Dr. Tchoungui also made stark comparisons between East and West Cameroon on several other aspects of medical infrastructure. He articulated the differences on the basis of general resources, but also on the differences in models used for things such as authority over dispensaries and patient payment for treatment. These models reflected the broad differences between French and British colonial administration in Africa. Whereas some East Cameroonian dispensaries fell under the public health authority, West Cameroon ran its dispensaries through the Native Authority Administration, with customary chiefs overseeing construction and financial functioning.<sup>408</sup> Dr. Tchoungui noted a limited number of state-hospitals in West Cameroon, and the relative importance of missionary-led hospitals in the region.<sup>409</sup> He characterized the hospital equipment as insufficient and noted that there were not specialized services available in the entire territory, making evacuations to Douala or Ibadan, Nigeria often obligatory.<sup>410</sup> Another great difference highlighted between East and West Cameroon was that most people in the West were required to pay for medical treatment. The Minister also characterized the formation of public health personnel between the two territories as “totally different” and noted the need to harmonize

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<sup>408</sup> NAC Buea. Sc/a 1964/14 *Organisation Générale des Services de Ministère de la Santé Publique et de la République Fédérale du Cameroun, par le Docteur S.P. Tchoungui, Ministre de la Santé Publique 1964*, 7.

<sup>409</sup> Ibid, 7.

<sup>410</sup> Ibid, 7. No statistics on how many individuals really did benefit from visiting medical specialists in Ibadan or Douala are provided.

the teaching methods.<sup>411</sup> With these observations, Dr. Tchoungui laid out some of the tasks ahead for health policy for the newly independent country, summarizing that although the overall health infrastructure of the country was satisfying, an immediate imperative was to reorganize and modernize it in East Cameroon, whereas the need existed to create it almost entirely from the ground up in West Cameroon, as was the case with certain regions of the East.<sup>412</sup> The overall number of biomedical personnel in West Cameroon was not, however, as starkly different as Tchoungui suggested. With West Cameroonians constituting roughly twenty-percent of the Federal population, the health personnel in the state constituted about fifteen percent of the total for the whole country. However, a much higher proportion of personnel in West Cameroon worked in the private sector. Thus, while 76% of medical personnel in East Cameroon worked for the state, only 46% did so in West Cameroon.<sup>413</sup> In turn, private medical establishments, including missionary posts and the medical establishments of the plantation corporations, played a relatively bigger role in West Cameroon.<sup>414</sup>

While East Cameroonian health officials viewed West Cameroon through the lens of insufficiency, West Cameroonians lamented the lack of respect for and recognition of the differences of their system by East Cameroonians. In a 1963 letter to Dr. Tchoungui entitled “Medical Policy for West Cameroon,” West Cameroonian Prime Minister and Federal Vice President Foncha bluntly expressed his dissatisfaction over recent discussions between the two

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<sup>411</sup> Ibid, 29.

<sup>412</sup> Ibid, 21.

<sup>413</sup> In 1964/65, of a total of 164 doctors in East Cameroon (including “médecins-africains), 112 worked in the public sector. Of the 32 doctors in West Cameroon, 15 worked in the public sector. These numbers include foreign doctors as well as Cameroonians. The total size of the medical corps in East Cameroon (private and public, including unskilled workers) was 6199. The total corps in West Cameroon was 1117. See Appendices for more detailed information: Table: Medical and para-medical personnel in Cameroon 1964/1965.

<sup>414</sup> See Appendices: Medical Establishments in Cameroon 1964/1965.

during a recent visit of his to Yaoundé about the running of hospitals in the anglophone region. He wrote to Tchoungui, “to inform you that your present plans seem to have ignored all the existing medical policies and plans made before Unification.” He continued, “It seems to me that you are trying to carry exactly the same policy as exists in East Cameroon into West Cameroon without looking or enquiring from us what our plans were.”<sup>415</sup> Foncha specifically listed the wish to continue a policy of ‘grants-in-aid’ for the running of medical facilities by missionary groups, and the Native Administration authority over building and financing local dispensaries and maternities.<sup>416</sup> Other complaints involved the Minister ignoring a site chosen by local personnel for the building of a new hospital in favor of a different site, and a directive sent to the Director of Medical Services in West Cameroon stating that personnel transfers in the region would go through the ministry in Yaoundé. Foncha wrote that this could not possibly be a sound course of action, given the limited knowledge of the ministry on local matters and staff.<sup>417</sup> He suggested a compromise in having the Director of Medical Services in West Cameroon initiate any transfers and put them to approval from the Minister. He concluded the letter with a more general statement about the governmental relationships at play: “Remember that your work is to improve the medical facilities for the people of West Cameroon and we,

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<sup>415</sup> NAC Buea. Sc/z 1962/7 *Services de Santé au Cameroun Occidental*. March 25, 1963 ‘Medical Policy for West Cameroon’ from Foncha. To the Hon. Minister of Health, Yaoundé.

<sup>416</sup> Foncha had written another letter more specifically on these two policies a month prior. National Archives of Cameroon, Buea. Sc/a 1962/7 *Services de Santé au Cameroun Occidental*, Letter dated February 1, 1963, Subject: “Government Policy for Mission Hospitals.” From Foncha to the Minister of Health. He wrote: “It has always been the policy of West Cameroon Government to assist the Missionary Bodies in their zeal to establish hospitals in West Cameroon. This is a custom which we inherited from the British, and which is also in practice in Nigeria.” He listed hospitals ‘built and staffed by Missionary Bodies with the consent and assistance of the Government.’ (includes the Baptist, Roman Catholic and Basel Missions)

<sup>417</sup> Foncha March 25, 1963. “Medical Policy for West Cameroon.” “Your offices may have the names, but the behavior of the individual members of the staff could not possibly be known to any member of your office.”

who are benefitting from this, should be able to say what we want.”<sup>418</sup> Foncha made powerful statements both about the specificity of the West Cameroonian medical system—such as a much more decentralized approach and reliance on missionary groups and local authorities—as well as trenchant questions about the role of the public in public health. The system he sought to protect was a product of colonial administration, but in West Cameroon this system also entailed a higher degree of reliance on and autonomy of local authorities. The question of how much the medical systems of West Cameroon should and would mirror those of the East reflected broader concerns about the influence of West Cameroonians themselves on these decisions.

The positions Cameroonians took in the process to define the public health future of the independent state were, therefore, not exclusively protections of the legacies of colonial administration and infrastructure. Cameroonian officials also infused these positions with an emphasis on their own stake in these systems in the postcolonial context. The significance of upholding existing systems served as a measure of their own relative stake and influence in how health structures would develop. At the same time, individuals who had been trained to work in one system or another were also protecting the integrity of their training and their work. In this regard, Cameroon faced unique circumstances in its first decade of independence. The questions faced were not just those of Cameroonian doctors or nurses taking over where Europeans had once held control, but also of negotiating the coming together of training and experience in two different medical systems, in two different languages.

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<sup>418</sup> Ibid.

The existence of these two professional working languages inevitably led to problems of communication. In November 1963, Minister of Public Health Dr. Tchoungui issued a “Technical Circular relating to vaccinations for those going on a pilgrimage to Mecca.” The original copy written in French was stamped as having been delivered to the West Cameroon Prime Minister’s Office ‘Translation Bureau’ which then reproduced the document in English for readership by West Cameroonians officials. This document is just one example of a process that was followed for countless other official documents, but reading the French and English copy side by side provides some insight into the extent to which issues could be lost in translation in these early days of the Federal Republic. The original French document lists the three vaccines required for the pilgrimage by international regulation: ‘antivariolique, antiamarile, anticholérique.’ The English translation listed the vaccine requirements as follows: “against smallpox, antiamarile (?), against cholera.”<sup>419</sup> The question mark next to the word ‘antiamarile,’ a French term for the yellow fever vaccine, reappears throughout the English version of the document, showing the inability of the translator to provide an equivalent for this technical term. Public health and medicine across the federation lacked a shared technical vocabulary in the most basic sense, and the process of translation undoubtedly led to these instances of miscommunication or complete inability to communicate.

The ideals of the officially bilingual federal republic faced concrete limits.<sup>420</sup> The establishment of translation bureaus in state prime minister’s offices, in the presidency and in

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<sup>419</sup> NAC Buea. Sc/a/1962/4, ‘Circulaire Technique relative à la pratique des vaccinations réglementaires requises pour le pèlerinage de La Mecque.’ Yaoundé le 5 Novembre 1963, Le Docteur S.P. Tchoungui, Ministre de la Santé Publique et de la Population.

<sup>420</sup> Jacques Benjamin, *Les Camerounais Occidentaux: La Minorité dans un État Bicommunautaire* (Montréal : Les Presses de l’Université de Montréal, 1972), 124-132. Benjamin discusses the limits of bilingualism in the context of the newly created Federal University in Yaoundé.



some ministries sought to bring bilingualism into the functioning of the government. The reality, however, was often quite different from the ideal of creating all federal documents in both languages given the limited number of truly bilingual staff.<sup>421</sup> Equally important, the work that went into creating bilingual documents and holding meetings and conferences with interpreters often slowed down administrative work and communication in the early years of reunification.<sup>422</sup> The energy spent on institutionalizing this official bilingualism meanwhile did not even begin to broach the much larger complexity of the African languages also spoken by Cameroonians<sup>423</sup> or the limitations on the number of people who spoke formal English or French at this time. The problem of translating the memo on vaccination illustrates a broader challenge at reunification, while also highlighting the particularly high stakes of this issue for public health and medicine. Technical vocabulary of medicine may have been less familiar to non-medical staff performing translation services, and yet the stakes of incorrectly identifying medicine and vaccines were incredibly high. The issue of bilingual translation in medicine thus represented much larger issues about the capacity of the new state to protect the health of its citizens.

### **French Doctors in West Cameroon**

Differences in language certainly undermined the ability of Cameroonian officials to seamlessly exchange information on health-related matters, but the question of language also provoked controversy and created complication at both the broader level of foreign aid and at

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<sup>421</sup> Beban Sammy Chumbow, "Language and Language Policy in Cameroon," in *An African Experiment in Nation Building: The Bilingual Cameroon Republic Since Reunification*, ed. Nvida Kofele-Kale. (Boulder, Colorado: Westview Press, 1980.), 290.

<sup>422</sup> Ibid, 290.

<sup>423</sup> Chumbow, 301.

the most intimate level of doctor-patient exchanges. These two factors intertwined through the presence of French doctors sent to work in West Cameroon after reunification. The close ties maintained between Cameroon and France after independence, resulting from the initially separate trajectory of decolonization in East Cameroon, greatly shaped the development of health policy and personnel in the 1960s. But while the impact of this development on Cameroon's medical culture and structure are in many ways emblematic of the Franco-African ties redrawn and bolstered at independence, an important question remains of what these ties meant in the context of the federation—a political entity marked by the ideals of official bilingualism and a more complicated colonial past. The work of French doctors in West Cameroon in many ways shows the regional limits of the privileged Franco-Cameroonian culture of the medical world, while also highlighting the ambiguity of national versus international health work at this time.

In the early 1960s, a new crop of foreign doctors began working in West Cameroon, both under the auspices of the World Health Organization and the French Government. The World Health Organization originally sent six doctors of varying nationalities in the early 1960s through an agreement with the Cameroonian government to assist with the development of medical services.<sup>424</sup> French doctors also came to the Anglophone state as part of the broader program of technical assistance established between the French and Cameroonian governments after independence. The numbers of these foreign doctors were small in the early 1960s, but this must be placed in the context of the very low numbers of biomedically-trained, state

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<sup>424</sup> WHO. Project Files-Cameroon 4002. See also *WHO Annual Report to the Regional Committee for Africa on the activities of the WHO in the African Region, 1 July 1963-30 June 1964*. AFR/RC14/3, 60; *Fourteenth Session of the WHO Regional Committee for Africa, held in Geneva, Switzerland from 14 to 21 September, 1964. Final Report and Minutes of the Meeting*. Brazzaville, November 1964, 62-63. Dr. Dibue noted at the 1964 meeting that only two of the original 6 WHO doctors sent remained in the country by 1964.

recognized doctors in West Cameroon at the time.<sup>425</sup> A total of 14 doctors, most of them foreign, worked in all of West Cameroon in 1962<sup>426</sup> and the number had grown to 32 by 1964.<sup>427</sup> Nurses and medical auxiliaries instead comprised the majority of medical personnel at this time.

The French government sent this handful of physicians to West Cameroon in the early 1960s through the Ministry of Cooperation in the interest of extending French influence and gaining a ‘foothold’ in the anglophone territory.<sup>428</sup> As a former British territory, the French government saw West Cameroon as a unique avenue through which to extend its influence in Africa. French interventionist approaches to West Cameroon also grew out of concerns that the legacy of British rule left the territory open to ‘anglo-saxon’ influence and contributed to a desire to make an imprint through technical assistance, infrastructural investment and cultural programming. The French Ambassador to Cameroon in 1962 saw the extension of this French influence as a key concern, and he identified French doctors in West Cameroon, some of the few French technical assistance personnel in the region, as one of the few concrete efforts towards exerting this influence.<sup>429</sup> The French Ambassador recognized the obstacles to

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<sup>425</sup> I do not account here for other healers within Cameroon, working outside of the biomedical framework.

<sup>426</sup> CADN 131PO/1 No 27. Buea Consulat, Consulat de France à Buea, Cameroun Occidental “Etat des Services Sanitaires au Cameroun Occidental, 1er trimestre 1962,” p. 2. Of these 14, 9 worked in government hospitals, 4 for the Cameroon Development Corporation, and 1 for a mission. Of these, 1 was a French military doctor of the ‘Service de Santé des Troupes de Marine,’ 4 were World Health Organization. Other contractual doctors of ‘varying nationalities’ were also part of this 14. More French doctors were sent to West Cameroon after 1962.

<sup>427</sup> Note that this source puts the number at 33, while the table above puts the number at 32. James G. Roney, Jr. *Health and Medicine, Volume III of: The Economic Potential of West Cameroon—Priorities for Development*. Prepared for the Government of the Federal Republic of Cameroon and the Government of the Federated State of West Cameroon (Menlo Park, California: Stanford Research Institute, 1965). As of 1964 there were also 263 licensed “native doctors” in West Cameroon.

<sup>428</sup> Interview with Dr. Thomas C. Nchinda, May 22, 2014, Founex, Switzerland. See also: Lachenal (2006), 407.

<sup>429</sup> CADN, 743PO/2/3, Letter dated 14 Dec. 1962, Jean-Pierre Benard, Ambassadeur de France au Cameroun à Monsieur le Ministre des Affaires Etrangères, Direction des Affaires Africaines et Malagaches, “Voyage au

extending influence in West Cameroon, remarking after a trip to the territory that he found not one person there who understood French, but he equally interpreted the widespread use of pidgin English by West Cameroonians as a sign of the limited cultural “penetration” of the British.<sup>430</sup> To be sure, the approaches towards Cameroon that the British and French governments took after independence developed in starkly different ways. Many British expatriates left the territory in the early 1960s<sup>431</sup> and British policy makers reacted to the strong ongoing influence and presence of the French in Cameroon. Due to this ongoing influence of French policy in East Cameroon, the British government came to see the federation in its entirety as first and foremost a French partner.<sup>432</sup>

The nature of this French ‘foothold’ created in West Cameroon through the doctors’ presence, however, did not develop quite as intended. The behavior and work of the French doctors provoked controversy in various instances in the early 1960s with complaints from Cameroonians ranging from lack of respect for political authorities to gross professional negligence. Much of this controversy revolved around incidents at the General Hospital in Victoria.

One controversy that arose revolved around a lack of respect shown by the doctors for West Cameroonian political figures. In early August 1964, the wife of the Prime Minister of

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Cameroun Occidental.” See also: CADN Box 743PO/2/4, Letter dated 25 Mai 1963, Camille Scalabre Chargé d’Affaires a.i au Cameroun à Monsieur le Ministre des Affaires Etrangères, Direction des Affaires Africaines et Malgaches, “Voyage au Cameroun Occidental et installation de notre nouveau Consul à Buea.”

<sup>430</sup> CADN, 743PO/2/3, Benard 14 Dec. 1962.

<sup>431</sup> CADN 743PO/2/3, Benard 14 Dec. 1962.

<sup>432</sup> Torrent, *Diplomacy and Nation-Building in Africa: Franco-British Relations and Cameroon at the End of Empire*, 79. Jean-François Bayart, “La politique extérieure du Cameroun (1960-1971),” *Revue Française d’Études Politiques Africaines* 75 (1972) : 51.

West Cameroon and Vice President of the Federal Republic, made an official planned visit on behalf of the Cameroon Red Cross Society to the hospital in Victoria, but none of the three French doctors posted there reported to the hospital on the day of her visit to greet her. Many people in West Cameroon saw this as a major lack of respect for the authority of the country, with both the Federal Inspector and Director of Medical Services in West Cameroon writing to the Minister of Health to complain.<sup>433</sup> An anglophone newspaper, *The Cameroon Times*, published an editorial soon after the visit, entitled ‘Punish this Insolence.’ The editorial stated

We abhor the temptation to sound parochial and clannish but we note that these members of the hospital staff who so disrespectfully stayed away, are all expatriate personnel. And the three doctors are all of French origin. We want to ask very bluntly whether such disrespect would be showed to the wife of the French Head of State if she visited an institution where these doctors were working—even in her private capacity, much more as an official of an organisation of world-wide fame as the Red Cross Society? It is a sad reflection on our status as an independent nation that some expatriates in our midst can still treat our leaders with great impudence and get away with such insults unpunished....Lest we be misunderstood, we have nothing against Frenchmen in general. In fact, we have the highest esteem for those French nationals who are contributing effectively and sincerely towards the growth of Cameroon. But we certainly would ask that stern disciplinary measures be taken against any person who shows disrespect to our leaders whether they be Frenchmen, Jamaicans, Germans, Britons, or even Cameroonians.<sup>434</sup>

This moment may be read broadly as an instance of Cameroonians protecting the new status of the independent nation, but the specific significance of this instance involving Frenchmen can also not be overlooked. The lack of a shared Franco-Cameroonian past and future in West

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<sup>433</sup> NAC Buea. Sc/a 1962/7, *Services de Santé au Cameroon Occidental*. Letter dated 10 August 1964, Jean-Claude Ngoh, L’Inspecteur Fédéral d’Administration à Monsieur le Ministre de la Santé Publique et de la Population; Letter dated August 3 1964, G.G. Dibue, Director of Medical Services to the Federal Minister of Health, ‘Discourtesy to Her Excellency- Madame Foncha.’

<sup>434</sup> NAC Buea. Sc/a 1962/7 Copy of Cameroon Times editorial Vol. 4 No. 101, Tuesday August 4, 1964. The editorial further complained that the same doctors ‘coldly ignored’ a Secretary of State that had visited the hospital the week before, and a recent incident with a French merchant in Victoria refusing to fly the Cameroonian flag.

Cameroon, an ideal regularly touted in the medical field in East Cameroon in the 1950s and 60s, frames the significance of this interaction. The very irrelevance of the doctors' Frenchness, the assertion that such disrespect by *anyone* would be reprehensible showed just how different the dynamics of the medical profession were in West Cameroon. French and East Cameroonian doctors had developed a shared, albeit hierarchical, professional world with its own norms of conduct<sup>435</sup> but this tradition had no roots in West Cameroon. Frenchmen were foreigners, without ties of 'familiarity,'<sup>436</sup> and their behavior was judged accordingly.

Moreover, the question of language became central to the controversies over French doctors working in West Cameroon, with many Cameroonians complaining that the language barrier left the French unequipped to care for patients in the territory. The protests in Victoria described at the beginning of the chapter revolved partially around this issue. After the death of a West Cameroonian in the hospital, the Security Service office of Victoria reported to the Federal head of security in a letter entitled "Language Difficulties by French Speaking Doctors at General Hospital Victoria-Caused Public Alarm." A prominent figure in the West Cameroonian government had been admitted to the hospital on August 20<sup>th</sup>, 1965 and had died there on September 1<sup>st</sup>. The Security Service reported popular speculations that the death resulted from the patient not being well attended to by the hospital doctors and that he would have been better off going to Nigeria for care. People were also articulating the incompetence of the doctors as largely *related* to the problem of language, saying that unqualified interpreters were translating patient histories to the doctors and leading to improper treatment. French doctors were also writing prescriptions in French to leave by patient bedsides, which the West

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<sup>435</sup> Lachenal (2009).

<sup>436</sup> Lachenal (2009).

Cameroonian nurses were not able to read and understand. The Security Service finished the report letter by endorsing the suggestion that only doctors who spoke English be posted to West Cameroon.<sup>437</sup>

Another death in the hospital also sparked outrage the same year. In 1965 a woman died in Victoria hospital from an obstructed labor. All of the French doctors had left the hospital for the weekend and were not present when the patient arrived. In an interview I conducted with Dr. Thomas Nchinda, a doctor in West Cameroon at the time, he remembered that women of Victoria took to the streets to protest the death and circumstances at the hospital. “They were going to march to see Mr. Foncha in Buea. They said, we told you from the start we don’t want these French doctors coming in here, they don’t speak English, we can’t talk to them, we don’t have interpreters, how can you talk to the doctor?”<sup>438</sup> After the death of the female patient, the women of Victoria first marched to the office of the Director of Medical Services for West Cameroon, Dr. Godfrey G. Dibue, in Victoria, threatening to march to Mr. Foncha’s office in Buea if something was not done. Dr. Dibue presented the issue to the Minister of Health in Yaoundé in meetings also attended by the French technical advisor to the ministry. Dibue proposed that the only way to appease the community would be to post a Cameroonian doctor as medical officer in charge of the hospital. As a result of these meetings and the controversy,

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<sup>437</sup> NAC Buea. Sc/a 1962/7-*Services de Santé au Cameroun Occidental*, Letter dated 7<sup>th</sup> September 1965 “Language Difficulties by French-Speaking Doctors at General Hospital Victoria-Caused Public Alarm”. From the Security Service Victoria to the Director Federal Sûreté, Yaoundé.

<sup>438</sup> Interview with Dr. Thomas Nchinda, Founex, Switzerland. May 22, 2014. Dr. Nchinda was born in the mid-1930s in British Southern Cameroon in a village near Kumba. He completed his medical studies at the University of Ibadan, Nigeria and then returned to Cameroon in the early 1960s. In the late 1960s he served as Deputy Delegate and then Delegate for to the Commissioner of Health for West Cameroon, the equivalent of the former Director of Medical Services for West Cameroon position.

the ministry transferred Dr. Nchinda from his posting in Kumba to be in charge of the Victoria hospital.<sup>439</sup>

Dr. Nchinda remembers his new position feeling like being “a sheep in a lion’s den,” faced with the circumstances of being much younger than the French doctors, not being from the same professional milieu of their military training, and the fact that they were “always bosses wherever they were.”<sup>440</sup> When visiting hospitals in the Eastern state of Cameroon, he remembers that ‘The French medical doctors did what they please, how they please, when they pleased.’ The French doctors complained about being under Dr. Nchinda’s direction to the French Technical Advisor to the Cameroonian Minister of Public Health, but since the advisor had been privy to the meetings on the matter, there was little room for change. Dr. Nchinda remembers the dynamic improving only one to two years after his appointment when he felt he won the respect of the other doctors. A French surgeon posted to the hospital had asked Dr. Nchinda to cover his call for the hospital one weekend in order to entertain visiting friends. An emergency surgery arose over the weekend, which Dr. Nchinda handled, and he remembers finally being appreciated more as an able doctor and colleague from that point forward.

In complaining about the French doctors, many West Cameroonians repeated the common refrain that they did not speak English, but the dichotomy of English/French did not capture the full linguistic complexity at play in doctor-patient interactions in West Cameroonian hospitals. The dynamics that Dr. Nchinda described in Victoria hospital were about more than just language. Notably, Dr. Nchinda did not draw the distinction between just the ability to speak English or French, but emphasized the benefit of speaking the pidgin English language of

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<sup>439</sup> Ibid.

<sup>440</sup> Dr. Nchinda was in his early 30s at the time and the French doctors he remembers being in their 50s.



West Cameroon in dealing with patients. He remembered the need to sometimes use subtle language, ask leading questions, and sometimes even humor to work with female patients in West Cameroon, particularly for obstetric problems.<sup>441</sup> At his posting in Kumba, Dr. Nchinda had also worked with a World Health Organization doctor of Greek nationality who did speak English, but Nchinda noted that the problem was really that he did not speak pidgin. He talked about patients preferring to consult with him over the WHO doctor at that hospital. He saw this as a natural outcome, “because not only was I a Cameroonian, but because I would get into the intricacies of the pidgin, with even the most, most illiterate. And because it is my country and I have grown up there, I know even the background and some of the reasons why they do what they do.”<sup>442</sup> Although the discourse of complaining about foreign doctors in West Cameroon often revolved around the complaint of them not speaking English, the needs of clear doctor-patient communication were actually much more complex and steeped both in the ability to speak the regional pidgin as well as having the cultural context for the language and appropriate ways of communicating about health behaviors and situations.

But the situation Dr. Nchinda describes also contrasted sharply with certain dynamics of the medical profession in East Cameroon at the time. Historian Guillaume Lachenal has convincingly shown how the intimate ties between French and East Cameroonian medical workers trained in the French system shaped the medical and scientific realms in Cameroon after independence.<sup>443</sup> Important questions remain, however, about the geographical limits of this ‘familiarity’ within the independent Cameroonian state, as well as the significance of these

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<sup>441</sup> Interview with Dr. Thomas Nchinda, Founex, Switzerland. May 22, 2014.

<sup>442</sup> Ibid.

<sup>443</sup> Lachenal (2009).

ties in the context of an officially bilingual country. French and Cameroonian doctors in West Cameroon did not share the language, both literally and figuratively, with which to talk about a professional medical culture rooted both in a common past and active present.

Perhaps no example is more emblematic of this rift between the legacy of French colonial medicine in East Cameroon and its irrelevance in West Cameroon than the experience of French physician Dr. Jean Jamot in West Cameroon in 1966. Jean Jamot was the son of Eugène Jamot, the much celebrated creator of the French mobile health team model. As evidenced in Dr. Tchoungui's discussion of the mobile health service, francophone Cameroonian medical workers regularly referenced Jamot as endowing them with a very particular and important medical legacy to honor and uphold.

The son of this chosen hero of francophone Cameroonian medical history did not fare as well in the anglophone territory. Dr. Jean Jamot had been working in Algeria when he was given the choice for his next posting through the French system between Cameroon and other countries. He chose Cameroon in memory of the work of his father.<sup>444</sup> His ultimate stationing at the General Hospital in Bamenda in West Cameroon, however, didn't seem to work for anyone involved. Reports indicated that he had "no notion of English," which made it impossible to do consultations or to write prescriptions.<sup>445</sup> Faced with these circumstances, Dr. Jamot wrote to the Ministry of Public Health to request that he be reposted in francophone East Cameroon. The outcome of his request is not discernible from archival documents in Cameroon, but it is notable that the son Jamot does not appear in any other of the available

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<sup>444</sup> National Archives of Cameroon, Buea. Sc/a/ 1962/7, confidential letter dated January 1, 1966. Origine: B.M.M Bamenda à Inspecteur Fédéral à Buea

<sup>445</sup> Ibid. My translations.

medical archives from West Cameroon from the 1960s. His stay in the region was likely quite brief.

Jean Jamot's discontentment in the region and his apparent inability to effectively practice medicine in West Cameroon provides a stark contrast with the experience of his famous father, a contrast through which to see the limits of the reach of a celebrated legacy of French colonial medicine as well as a post-colonial future in Cameroon. Rhetoric and ritual to celebrate this past and the future of Franco-Cameroonian 'Cooperation' that may have resonated in Yaoundé fell flat in West Cameroon. In this context, French doctors were particularly inept foreigners, ill-equipped to engage with the most basic elements of local communication and expectations. They were stripped in this context of the claims to insight into local cultures or the medical terrain that some French doctors made on the basis of careers in the colonies.

Whereas in East Cameroon the tight relationships of French and Cameroonian personnel that underpinned the medical system became the basis for international health programs and institutions to work with the country, in West Cameroon the French doctors were as much actors of 'international health,' in the sense that they were seen and functioned almost entirely as external players in an unfamiliar realm. French doctors in East Cameroon could make claims to understanding the local context and thus position themselves as international intermediaries, but on the ground in West Cameroon this positioning was quite precarious. French doctors were in fact singled out in a more targeted way than those World Health Organization doctors placed in Cameroon who at least spoke English, even if this language, spoken formally, still presented barriers to patient communication. The French doctors were outsiders to the utmost extreme—both expatriates and unable to speak the language needed for medical work. In independent Cameroon, the demarcations of who engaged in work that we

might call national and work that would be called international health work were deeply ambiguous.

The influence of French physicians, however, and their impact on the Cameroonian medical world did not reside solely in personnel on the ground. The medical infrastructure of East Cameroon at independence was deeply ingrained in the French colonial past and a future predicated on *Coopération*. Cameroonian officials saw the extension of this infrastructure to West Cameroon as either a necessity or an imposition, depending on their position within the federation. This next section will look more closely at the work to extend the mobile health team system of East Cameroon to the West, a system considered by health officials in East Cameroon to be both emblematic of the imprint (and benefits) of French colonial administration as well as having the potential to fill what they perceived as the biggest lacuna in the West Cameroonian medical system.

### **Extending Mobile Health Teams**

The push from Yaoundé to extend the mobile health team system of East Cameroon to the western state grew out of the idea formed by francophone Cameroonian and French officials that the former British territory had no comparable system for rural preventive care. As discussed earlier in the chapter, Dr. Simon-Pierre Tchoungui, the Minister of Public Health from 1961-1964, deplored the lack of mobile health teams for rural care in West Cameroon.<sup>446</sup> A 1962 report from the newly established French consulate in Buea in West Cameroon also observed that there were one or two mobile health teams in the area, ‘theoretically’ charged

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<sup>446</sup> NAC Buea. Sc/a 1964/14 *Organisation Générale des Services de Ministre de la Santé Publique et de la République Fédérale du Cameroun, par le Docteur S.P. Tchoungui, Ministre de la Santé Publique 1964.*

with smallpox vaccination among other tasks, but that the program was not well established along set geographical circuits and suffered from a major lack of personnel and finances. The report concluded that the efficacy of the mobile team here was basically ‘null’ for most of the rural population and that the organization of the *Service des Grandes Endémies*, must be set up in the territory.<sup>447</sup>

International health observers and officials also reported on the situation of the mobile teams in the early-mid 1960s. The Cameroonian government drew for its health planning on a variety of these externally prepared reports on the medical infrastructure of the Federal Republic. One such report, prepared by the World Health Organization by a public health advisor to Cameroon, suggested that the government give greater attention to the coordination of the *Service des Grandes Endémies* in West Cameroon.<sup>448</sup> An American doctor who prepared a report on economic planning for the government of Cameroon led a study from June 1964-February 1965 that included visits to medical facilities in West Cameroon and interviews with public health officials across the federation. In studying the relationship between federal-level and state-level health programs, he examined how the federal level *Services des Grandes Endémies* connected with work in West Cameroon. Based on interviews with the officials he met, he wrote that “inadequate liaison between Yaounde and Buea were cited by officials in both East and West Cameroon as one reason why West Cameroon has not become a more active participant in these programs [of the *Grandes Endémies* office of the Ministry of Public Health]. The lack of communication between East and West Cameroon is partly an outgrowth of staff

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<sup>447</sup> CADN, Box 131PO/1/27, No 27. Buea Consulat, Consulat de France à Buea, Cameroun Occidental “Etat des Services Sanitaires au Cameroun Occidental, 1er trimestre 1962, 8.

<sup>448</sup> WHO M 2/3723 Cameroon. Programme for Malaria Eradication in Cameroons. Dr. M. Torfs, Public Health Advisor, “Main Aspects of Planning for Basic Health Services in the Federal Republic of Cameroon (1966-1980).” 1966.

shortages and partly a result of language problems and incompatible features of the French and British medical traditions.”<sup>449</sup> The fault lines between the systems of the two territories, rooted in the history of different colonial administration, were thus brought into the foreground as an important aspect of national health planning, both internally and in the context of consultation and engagement with international health officials.

These reports varied between concluding that there was not preventive rural care in West Cameroon to arguing that it was inadequate, but none explained fully what the existing system actually was. West Cameroon did have its own version of a traveling health service established under British colonial administration, called Medical Field Units. The Medical Field Units pursued a similar objective to the mobile health teams of East Cameroon. They toured rural areas diagnosing and in some cases treating diseases, and performing vaccinations.<sup>450</sup> The medical field unit assistants were male nurses that had formerly trained at the School of Hygiene in Aba, Nigeria, although no such program existed to continue this kind of training in West Cameroon.<sup>451</sup> The teams in the British Southern Cameroons had fallen under the larger umbrella of the Nigerian Medical Field Units structure, since the territory was administered as part of Nigeria.<sup>452</sup> British doctors created a similar system in other colonial territories, such as Ghana. Moreover, the doctors who created the system in the British colonies drew heavily from the French as well as Belgian models for combating sleeping sickness in creating the

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<sup>449</sup> Roney, 49-50. The report was completed through a contract between the Cameroonian government and the United States Agency for International Development (USAID).

<sup>450</sup> NAC Buea. Sc/1959/2, “Annual Medical Report of West Cameroon for the Year 1961.” “Annual Medical Report-West Cameroon 1963.”

<sup>451</sup> Roney, 35.

<sup>452</sup> J.L. McLetchie, “Medical Field Units in Nigeria,” *Transactions of the Royal Society of Tropical Medicine and Hygiene* 48 no. 2 (1954):

system. In the 1920s and 30s, as the service was being created in Nigeria, British doctors even went to observe the work of Dr. Eugène Jamot against sleeping sickness in French Cameroon and brought these observations back with them to Nigeria.<sup>453</sup> Also similar to those in French Cameroon, the teams in the British southern Cameroons served as the on the ground basis for an international health campaigns in the 1950s.<sup>454</sup>

In the early 1960s, there were at least three medical field units in the state, but a WHO official reported that in West Cameroon, “the activities of detection, prevention and treatment of major endemic diseases are entrusted in most cases to a number of non-qualified health workers who are only trained for a particular endemic disease: yaws scouts, leprosy inspectors...”<sup>455</sup> These personnel had not completed the more comprehensive training of the medical field unit assistants who had trained in Nigeria. The work of the Field Units was severely limited, moreover, if not halted entirely in some areas, by 1965 due to lack of finances and equipment.<sup>456</sup>

The work of the Field Units was never as robust in practice as it was in theory, but the same is certainly true of the mobile health teams under French colonial administration and in independent East Cameroon. The heroic claims made by French doctors about their work with the mobile health teams in the 1950s obscured a long history of shortcomings and in some

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<sup>453</sup> Ralph Schram, *A History of the Nigerian Health Services*, (Ibadan: Ibadan University Press, 1971), 238-239.

<sup>454</sup> The teams carried out a WHO/UNICEF-funded anti-yaws campaign. Buea, Sc/a/1949/5, Medical Field Unit (Epidemic Team); *Cameroons under United Kingdom Administration*. Report for the Year 1957. Report by Her Majesty’s Government in the United Kingdom of Great Britain and Northern Ireland to the General Assembly of the United Nations for the Year 1975, London: Her Majesty’s Stationary Office, 1958.

<sup>455</sup> WHO M 2/3723 Cameroon. Programme for Malaria Eradication in Cameroons. Dr. M. Torfs, Public Health Advisor, “Main Aspects of Planning for Basic Health Services in the Federal Republic of Cameroon (1966-1980).” 1966. {based on a survey of health facilities in 1964/65}

<sup>456</sup> NAC Buea. Sc/1959/2, ‘Annual Medical Report, West Cameroon, 1965.’

cases, medical disasters.<sup>457</sup> French and Cameroonian doctors overstated the difference between that two systems, at least in the sense of intent. One of the most important differences between the teams came through the imprint of the French medical military corps, and the ethos of militaristic-style campaigns that shaped the development of the mobile service. The teams in French Cameroon had thus operated according to more rigid schedules and procedure in their “assembly-line” village visits. While those in East Cameroon saw the West Cameroonian teams as lacking, some in West Cameroon saw superiority in their system in key areas such as environmental health, sanitation, and hygiene efforts.<sup>458</sup> Furthermore, in spite of structural differences, the reach and efficacy of the teams in both areas was geographically uneven in the 1950s and early 1960s.<sup>459</sup>

Despite the unevenness of the reach of teams, health officials working in Cameroon framed one of the most pressing questions of the mobile service as being that of harmonization and coordination of the systems across the country. This concern certainly reflected a broader political project of national standardization, but East Cameroonian health officials also upheld the mobile health service as one of the most significant aspects of public health administration. In the mid-1960s, Cameroonian officials took more concrete steps to bring the preventive health services of East and West Cameroon in alignment. The federal government put legislation into place in the spring of 1965 to further centralize public health administration at the federal level,

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<sup>457</sup> Jean-Paul Bado, *Eugène Jamot, 1879-1937 : Le Médecin de la maladie du sommeil ou trypanosomiase* (Paris : Éditions Karthala, 2011). Guillaume Lachenal, *Le Médicament qui devait sauver l’Afrique : Un scandale pharmaceutique aux colonies* (Paris : La Découverte, 2014), 57-101.

<sup>458</sup> Interview with Dr. Nchinda.

<sup>459</sup> For example: NAC 1AC 9413 ‘Prospection du SHMP dans le Mbam 1957’ on ongoing hostility to villages to mobile teams and absenteeism in the late 1950s; 1AA 502 Nord Cameroun, *Rapport Politique Trimestriel-2ème Trimestre 1963, Préfecture du Département du Diamare*. Reports that the work of the mobile health team in the area had been reduced due to insufficient funds.



which had important ramifications for preventive medicine across the federation.<sup>460</sup> The legislation sought to merge the Medical Field Unit Service of West Cameroon with the East Cameroonian *Service des Grandes Endémies* under the Director of *Grandes Endémies* in Yaoundé. A similar plan for harmonization and centralization went into place for the maternal and child welfare service.<sup>461</sup> The Director of Medical Health Services in West Cameroon at the time of the change, G.G. Dibue wrote

In centralizing two important sections of the health services as these two, one would have expected some consultations between doctors from each sector bearing in mind that the French system of *Grandes endémies* has its own merits and at the same time, the British method of eradicating major endemic diseases through the Medical Field Units has been praised by neutral observers of international repute. The writer had advocated since 1962 that before harmonization of any section of the health services, Cameroonians themselves, doctors or nurses or technicians should be chosen from East and West Cameroon and given the assignment of studying the type of work, methods and results achieved in each state and recommend what should be accepted as the model for Cameroon. The idea was to produce a cross pollination through the marriage of French and English systems of health services as practiced in East and West Cameroon. To ignore the West Cameroon Medical Association in such matters produced feelings of frustration, especially among Cameroonian doctors in West Cameroon who have felt that their feelings were ignored.<sup>462</sup>

Instead of the ‘cross pollination’ that Dibue had hoped for, he found himself instead with a plan for the extension of the French-originated system of mobile health teams.

The legislation put a legal finish on a process of expansion of the service that had already been put in motion. In 1964, the Cameroon federal government made a request to the French Ministry of Cooperation for financial support for the creation of three new bases for

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<sup>460</sup> NAC Decrees 65/DF/221 of 16 May 1965 and 65/DF/238 of 4 June 1965. *Agence Camerounaise de Presse*, No. 127 du Mercredi 9 Juin 1965 “Organisation du Commissariat General À la Santé Publique,” 4-5.

<sup>461</sup> NAC Buea. Sc/1959/2, G.G. Dibue, Director of Medical Services, Commissioner-General of Health’s Delegate “Annual Medical Report, West Cameroon, 1965,” April 23, 1966.

<sup>462</sup> Ibid, 1-2.

mobile health teams in West Cameroon. The Ministry of Cooperation agreed to provide for only two, honing in on Bamenda and Kumba as the priority areas, and requested the Cameroonian government to complete plans and cost estimates for the envisioned construction.<sup>463</sup> In 1966, Dr. Emile Elom Ntizouzo'o, the assistant deputy director of the *Service des Grandes Endémies et de Médecine Rurale* toured the major medical centers of West Cameroon—Victoria, Buea, Kumba, Bamenda and Mamfe—to study the possibilities of creating the new bases for the service in the western state.<sup>464</sup> The French Ministry of Cooperation ultimately provided funding for the establishment of two mobile team bases in West Cameroon in the highly populated zones of Bamenda and Kumba. The project funding description again reiterated the observation that West Cameroon had “no infrastructure adapted to the needs of preventive medical action”<sup>465</sup> and that “just up until the reunification of the two Cameroons in 1961, mobile medicine had not been practiced in West Cameroon.”<sup>466</sup> The organization of vaccination campaigns against smallpox and yellow fever, along with screening for other diseases such as leprosy in West Cameroon were characterized as presenting a “particular urgency.”<sup>467</sup> Through the agreement for aid, the French government, via the head of

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<sup>463</sup> CADN 744PO/1/31. « Conclusions de la Mission d'Etudes du Ministère de la Coopération au Sujet de la Participation du FAC à la Réalisation du Plan de Développement du Cameroun, Programme 1965 » 6 février-4 mars 1965. Ministère de la Coopération. »

<sup>464</sup> NAC « Le Docteur Elom en Tournée au Cameroun Occidental » *Agence Camerounais de Presse*. No. 189 du jeudi 18 Août 1966.

<sup>465</sup> CADN 744PO/1/40. *Convention de Financement no. 36/c/66/0 conclue entre le Gouvernement de la République Française et Le Gouvernement de la République Fédérale du Cameroun. Projet no. 144/CD/66/VI/0/19*, p. 7. My translations.

<sup>466</sup> CADN 744PO/1/32-‘Programme de Développement Economique et Social pour 1966.’ Comité Directeur du Fonds d'Aide et de Coopération 29 Novembre 1966, p. 39. My translation. The base at Bamenda was intended to serve through its mobile activities the departments of N’kambe, Wum, Bamenda, Nso and Gwofong. The Kumba base would service Victoria, Mamfe, Kumba and Ndian.

<sup>467</sup> CADN 744/PO/1/32, p. 39

the *Mission d'Aide et de Coopération à Yaoundé* would finance the construction of the base, and the Cameroonian federal government would finance the equipment and furnishing for the bases, as well as the personnel and material costs for their functioning.<sup>468</sup> The bases were envisioned as a means to coordinate preventive medicine in the regions in a more efficacious way, by providing a central point from which mobile teams could work to provide vaccinations and some basic care to rural populations.<sup>469</sup>

Notably, agreements for the financing of the bases continued to refer to the Cameroonian mobile health team service by the acronym for the service's name under colonial administration, 'SHMP,' standing for the *Service d'hygiène mobile et de prophylaxie* rather than the contemporary name used by the Cameroonian government, the *Service des Grandes Endémies et de Médecine Rurale*. Repeatedly and consistently through the reports on the project, the French Ministry of Cooperation used language that blurred lines of any changes to the mobile service made after independence, and instead wrote in a language suggesting a seamless continuation and extension of the colonial medical infrastructure.

The reorganization of the mobile health team service along federal lines in West Cameroon took shape by 1967.<sup>470</sup> This moment was in many ways a crossroads for public health administration in Cameroon, which will be discussed more fully in subsequent chapters. At this time, the mobile teams across Cameroon became intermediaries for the global Smallpox

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<sup>468</sup> CADN 744PO/1/40, p. 8

<sup>469</sup> CADN 744PO/1/32, p. 40. This particular model was also tied to evolving rural health care reforms that will be discussed more fully in Chapter 5.

<sup>470</sup> A. Delas, "La Trypanosomiase au Cameroun: Situation Actuelle, » *Rapport Final de la Quatrième Conférence Technique de l'OCEAC, Yaoundé du 21 au Janvier 1969*, 140 ; Archives Nationales du Cameroun, Yaoundé. « Visite Officielle du Chef d'Etat au Cameroun Occidental » *Agence Camerounaise de Presse* No. 10 du mercredi 7 mai 1969 ; « Le 1<sup>er</sup> Conseil National de l'UNC : Point de Départ d'une activité plus intense et plus étendue » *Agence Camerounaise de Presse*. 10 Novembre 1967-Numéro Spécial. »

Eradication Program, and United States funding for vaccines and supplies bolstered the work of the teams across the country. On one hand, it was in part the US-funding provided for the smallpox campaign that facilitated the reorganization of mobile health units in West Cameroon. At the same time, laying the ground work for harmonization of the systems between East and West Cameroon allowed health officials to present the country's health system as cohesive in its dealings with international organizations for planning this campaign. It was a culmination of East Cameroonian officials' consolidation of the state around Yaoundé and around institutions originating from French colonial rule. It was also a culmination of the long-celebrated trajectory of the mobile health teams in the Franco-Cameroonian medical world and of the assertion of this history as central to Cameroon's national and international health policy.

The significance of the extension of the teams was thus a culmination of developments spanning the 1960s, but it was also a point of departure. At the same time, Cameroonian public health officials began to reconceptualize how the mobile health teams would fit into the larger public health administration, in line with recommendations from the World Health Organization calling for strengthened rural health services. These recommendations called for a greater integration of curative and preventive medicine, and a potentially diminished role going forward for the mobile health service as it existed.<sup>471</sup> Anglophone Cameroonian doctors, moreover, continued to play an active role in medicine and public health, and they helped to forge new opportunities within the country for bilingual medical training and work. Thus while the harmonization of the mobile health team service from East to West Cameroon illustrates the prioritization of French institutions within the country, the future trajectory of the teams would

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<sup>471</sup> Chapter 5 examines this development.

be marked both by international influence and the unique circumstances of the Cameroonian state.

In this sense, public health illuminates many of the broader tensions and the trajectories of state institutions and politics in the first decade of Cameroon's independence. The broader tensions of federalism and bilingualism drove many of these particular concerns in the fields of public health and medicine. The difficulties of coordination of a variety of other issues across the federation, particularly issues such as currency and education, also came quickly to the forefront of public debate. But rather than just using public health as a lens through which to see the state, we can also see the politics of the Federal Republic as an illuminating context in which to view the regional politics of public health in postcolonial Africa in their own light. In many ways, Cameroon presented a microcosm of the fault lines of biomedical training, culture and legacy that would play out more broadly in the 1960s across national borders between former British and former French colonies in West and Central Africa. The forms of regional health cooperation between states that did and did not develop across African borders at this time were entirely based on these legacies, even in instances when diseases, and thus public health concerns, operated across other shared borders and other geographies.

Thus, we might see the significance of how Cameroonians during this time discussed in pointed ways the differences of health infrastructure in the two federal territories on two levels. First, these discussions were formative of the dynamics of creating national health policies in Cameroon and thus are essential for understanding that history. But second, these conversations brought into light some of the ways in which African medical elite in the region viewed the possibilities for public health work in the first decade of independence as they took control over the functioning of state health infrastructures created under colonial administration, as well as

how international actors and institutions would function in this context. The assessments they made were commentaries on the training they had received, the systems they had worked in during colonial administration, and how they saw these experiences in comparison to one another. These commentaries are in turn key to understanding how African public health officials saw the role of their states both in relation to one another and in relation to international health organizations.

## Chapter 4: Mobile teams and smallpox eradication

As Cameroonian and French health officials continued to re-formulate the place of the mobile health teams in the new national health administration, dramatic new plans for global disease eradication began to develop within international health organizations. The World Health Assembly of the World Health Organization first voted in 1959 to endorse a proposal from the Soviet Union for smallpox eradication.<sup>472</sup> The idea languished for many years at the level of the WHO until 1966-67 when the World Health Assembly voted to set up a budget for smallpox eradication and to initiate a plan for a ten-year global eradication program.<sup>473</sup> This bold new plan relied not on new postwar technologies such as DDT, but rather on the long-existing technology of vaccination.<sup>474</sup> Yet, in its vision for complete global disease eradication, this program exemplified all the ambitions of postwar international health rooted in technological solutions.

In West and Central Africa, the development of the smallpox eradication program meanwhile launched the United States as a significant new player in the realm of international public health. In 1965, the United States announced a plan to support a regional program for smallpox and measles vaccination in Western and Central Africa.<sup>475</sup> The United States Agency

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<sup>472</sup> Nancy Leys Stepan, *Eradication: Ridding the World of Diseases Forever* (Ithaca, NY: Cornell University Press, 2011), 194. This vote did not at first garner real support for an eradication program but was focused more on relieving Cold War tensions within the World Health Assembly. Historian Erez Manela has argued for a broader vision of international history through the study of the Smallpox Eradication program, pointing to it as an example of US/Soviet cooperation. Erez Manela, "A Pox on your Narrative: Writing Disease Control into Cold War History," *Diplomatic History* Vol 34, No 2 (2010): 299-323.

<sup>473</sup> Stepan, 208.

<sup>474</sup> Stepan, 187.

<sup>475</sup> Stepan, 210. For an analysis of the factors leading to the Johnson administration's decision to support the program: Bob H. Reinhardt, "A Global Great Society and the U.S. Commitment to Eradication," in *The End of a Global Pox: America and the Eradication of Smallpox in the Cold War Era* (Chapel Hill: University of North Carolina Press, 2015), 52-85.

for International Development (AID), a branch of the U.S. Department of State, had originally begun providing aid for measles vaccination in the region in the early 1960s, and the US Communicable Disease Center (CDC)<sup>476</sup> became involved to provide operational structure and personnel.<sup>477</sup> After American President Lyndon Johnson's announcement of support for smallpox eradication, CDC officials proposed that the existing measles vaccination program in West and Central Africa be combined with the smallpox eradication program.<sup>478</sup> By late 1965, American health officials were prepared to announce to health officials in West and Central Africa that USAID would fund a five-year program for smallpox eradication and measles control, with technical and operational direction provided by the CDC.

The history of the smallpox eradication program in West and Central Africa has to date been told primarily through the lens of the small cadre of American personnel who helped run the program.<sup>479</sup> Accounts of the US-funded regional program in the expansive WHO history of

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<sup>476</sup> Horace G. Ogden, *CDC and the Smallpox Crusade* (Atlanta, GA : U.S. Department of Health and Human Services, Public Health Services, Centers for Disease Control, 1987), 9. The CDC changed its name to the Center for Disease Control in 1970 and to the Centers for Disease Control in 1980, while maintaining the same acronym.

<sup>477</sup> Ogden, 21-22. The support for measles vaccination grew out of a visit in 1960 by Dr. Paul Lambin, Minister of Health for Upper Volta, to the National Institutes of Health (NIH) in the United States, where he learned about the new Edmonston B measles vaccine and requested that it be field tested in his country. Following the success of that trial, AID funded measles vaccination for children across Upper Volta between November 1962-March 1963. In 1963, AID subsequently extended funding for measles vaccination to Dahomey, Guinea, Ivory Coast, Mali, Mauritania and Niger. The CDC became involved at this stage to provide technical support for the program. AID further extended support for a measles program to begin in 1965-1966 to Cameroon, Central African Republic, Chad and Togo.

<sup>478</sup> Ogden, 24.

<sup>479</sup> Horace G. Ogden, *CDC and the Smallpox Crusade* (Atlanta, GA : U.S. Department of Health and Human Services, Public Health Services, Centers for Disease Control, 1987). William H. Foege, *House on Fire: The Fight to Eradicate Smallpox* (Berkeley: University of California Press, 2011). Joel G. Breman, "A Miracle Happened There: The West and Central African Smallpox Eradication Programme and its Impact," in *The Global Eradication of Smallpox*, ed. Sanjoy Bhattacharya and Sharon Messenger, (New Delhi: Orient BlackSwan, 2010, 36-60. James Pascal Imperato, *A Wind in Africa: A Story of Modern Medicine in Mali* (St. Louis: W.H.Green, 1975). Other historians have analyzed the program as an important event of Cold War history, opening opportunities for new perspectives on American involvement, on US/Soviet interactions, and on less commonly studied state actors such as the American CDC. Erez Manela, "A Pox on Your Narrative: Writing Disease Control into Cold War History," *Diplomatic History* Vol 34, No. 2 (2010): 229-323. Erez Manela, "Smallpox Eradication and the Rise of Global



the global smallpox eradication program similarly reproduce this focus on a small number of foreign personnel.<sup>480</sup> While these histories do acknowledge the role of the mobile health teams in former French colonies and of OCEAC in facilitating the eradication program, they frame these relationships through the lens of what it meant for the smallpox program, rather than what they meant for existing, and evolving, health administrations within Africa. Moreover, these histories almost entirely erase the role of African doctors, health officials and personnel in the campaign.<sup>481</sup> Notably, no in-depth histories of the smallpox campaign have been written by historians of Africa.

I seek in this chapter to reframe the significance of the smallpox eradication program in Cameroon as part of a longer history of negotiation through decolonization of the place of the mobile health teams as guardians of rural health intervention and purveyors of international health programs. First, I argue that French and Cameroonian health officials used the

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Governance,” in *The Shock of the Global: The 1970s in Perspective*, ed. Niall Ferguson et al., (Cambridge: Harvard University Press, 2010), 251-262. Bob H. Reinhardt, *The End of Global Pox: America and the Eradication of Smallpox in the Cold War Era* (Chapel Hill: The University of North Carolina Press, 2015). Bob H. Reinhardt, “The Global Great Society and the US Commitment to Smallpox Eradication,” *Endeavor* 34. 4 (2010): 164-172.

<sup>480</sup> Frank Fenner et al, *Smallpox and its Eradication* (Geneva: World Health Organization), 849-909.

<sup>481</sup> Ogden, ix. Ogden writes in the CDC history. “It should be emphasized that the programs described in this account were not ‘one-man shows,’ or even ‘two-man shows.’ In every country in which they worked, CDC personnel served as advisors—albeit very active ones—to their national counterparts and to the many national staff members who actually performed most of the task that made the programs successful.” That said, the history names, for example, the CDC officials who worked in Cameroon and other OCEAC states but does not name any Cameroonian doctors or health officials in the text. Dr. Thomas Nchinda of Cameroon is featured in a photograph of the “NCDC/WHO Orientation and Training Course, Atlanta, 1968” in the “Illustrations” portion of the book. Historian Sanjoy Bhattacharya has written extensively critiquing these top-town institutional histories, and has instead written histories that emphasize regional, national and local politics and actors in South Asia as drivers of the campaign. Sanjoy Bhattacharya, “International Health and the Limits of its Global Influence: Bhutan and the Worldwide Smallpox Eradication Programme,” *Medical History* Vol 57, Issue 4 (October 2013): 461-486. Sanjoy Bhattacharya, “The World Health Organization and global smallpox eradication,” *Journal of Epidemiology and Community Health* Vol. 62 No. 10 (October 2008): 909-912. Bhattacharya, *Expunging Variola: The Control and Eradication of Smallpox in India, 1947-1977* (New Delhi: Orient Longman, 2006). Sanjoy Bhattacharya, “Uncertain Advances: A Review of the Final Phases of the Smallpox Eradication Program in India, 1960-1980,” *American Journal of Public Health* Vol 94 No. 11 (November 2004): 1875-1883.

opportunity of the smallpox eradication program to assert the centrality of the *Service des Grandes Endémies* (SGE) and of the *Organisation de Coordination pour la Lutte contre les Grandes Endémies en Afrique Centrale* (OCEAC) as a framework for international health campaigns. They did so by insisting upon the use of the existing mobile teams for the eradication program as well as on US coordination with OCEAC states as a bloc. In so doing, French military doctors of the mobile service elaborated their role as local intermediaries of international health, creating new dynamics through work with American health agencies and officials. At the same time, Cameroonian officials saw this positioning as a way to bolster resources for the mobile teams and for regional health coordination. Health officials in West Cameroon, in particular, used the occasion of the smallpox program to work on bolstering vaccination systems and the flow of health resources to that region. Given the already low incidence of smallpox in Cameroon in the late 1960s, I ultimately assert that the significance of the smallpox program in Cameroon had less to do with the goal of eradication itself and more with how Cameroonian and French health officials leveraged the new resources and professional networks opened through the program.<sup>482</sup>

At the same time, I argue that the final stretch of the smallpox program revealed the limits of the OCEAC framework of regional health, rooted in the geography of French empire, in addressing smallpox's spread. With the last phases of the smallpox eradication program in

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<sup>482</sup> The most detailed national and regional histories of the smallpox campaign have been written by Sanjoy Bhattacharya about India. An important comparative difference here is that, while Cameroon had a relatively small number of smallpox cases by the start of the eradication program, India was one of the most important sites in the world in terms of smallpox cases and the pursuit of eradication. Sanjoy Bhattacharya, "The World Health Organization and global smallpox eradication," *Journal of Epidemiology and Community Health* Vol. 62 No. 10 (October 2008): 909-912. Bhattacharya, *Expunging Variola: The Control and Eradication of Smallpox in India, 1947-1977* (New Delhi: Orient Longman, 2006). Sanjoy Bhattacharya, "Uncertain Advances: A Review of the Final Phases of the Smallpox Eradication Program in India, 1960-1980," *American Journal of Public Health* Vol 94 No. 11 (November 2004): 1875-1883.

Cameroon focused on movement across the border with Nigeria, it was the absolutist goal of global eradication that mobilized concerted action in addressing the spread of the disease in new ways. This aspect of the story thus shows the limits of post-colonial state frameworks for health, rooted in colonial geographies, in the face of the mobility of people across space rooted in a deep African past.

These perspectives offer a rejoinder to recent scholarship arguing that, because the global smallpox eradication program asserted global over local humanitarian concerns in Africa, “it is in fact a history that cannot be written from the vantage points of African states; the story much be told through its creators, the WHO, the CDC and to a lesser extent AID.”<sup>483</sup> This chapter will seek to show how aspects of this history can indeed be written from the vantage points of African states. While supporting the point that the global vision of disease eradication did not mirror local concerns in many ways, I hold that the participation in the program by Cameroonian officials often served other political purposes.

The chapter begins by offering a brief background on smallpox in Cameroon in the colonial period and early 1960s, and the role of the French mobile health service in smallpox vaccination. It then moves to the launch of planning for the smallpox eradication program during the first technical conference of OCEAC in Yaoundé in 1965. After showing how French and Cameroonian officials shaped the operation of the program through OCEAC, I examine how the program operated in anglophone West Cameroon. Finally, the chapter

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<sup>483</sup> Luise White has written that “the history of the smallpox eradication campaign reveals the fragile and defenseless statehood achieved by African nations in the 1960s and the triumphs of global humanitarian concerns at the expense of local sovereignty and local humanitarian concerns. It is in fact a history that cannot be written from the vantage point of African states; the story must be told through its creators, the WHO, the CDC and to a lesser extent AID.” Luise White, “Differences in Medicine, Differences in Ethics: Or, When is it Research and When is it Kidnapping or is that Even the Right Question,” in *Evidence, Ethos and Experiment: the Anthropology and History of Medical Research in Africa*, ed. P. Wenzel Geissler and Catherine Molyneux (New York: Berghahn Books, 2011), 450.

analyzes the persistence of smallpox in the late 1960s in northern Cameroon, questions about the spread of disease across the Nigerian border, and the ultimate success in eradicating smallpox in Cameroon.

### **Mobile Health Teams and Smallpox Vaccination**

The central issue of smallpox vaccination in colonial French Cameroon, as well as in the independent state, was undoubtedly framed by two distinct and sometimes competing forms of mobility: that of the mobile health teams and that of people within and across borders. In 1932, French officials made smallpox vaccination compulsory in Cameroon and called for vaccinations to be done every six years.<sup>484</sup> The mobile health teams soon took up the mantle of providing these vaccinations through their work of traveling to villages and assembling people for disease screening and vaccinations.

Mobile teams intensified vaccination schedules in response to outbreaks of the disease.<sup>485</sup> After an outbreak of smallpox in 1944, the reported number of smallpox cases in Cameroon stayed relatively stable and low in the years immediately following World War II. Between 1951 and 1952, epidemics broke out in the northern region of the territory. The French reported 721 cases of smallpox in 1951 and 1,105 cases in 1952.<sup>486</sup> In 1951, the mobile

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<sup>484</sup> William H. Schneider, "Smallpox in Africa during Colonial Rule," *Medical History* 53 (2009): 214. France had instituted a compulsory smallpox vaccination law in the rest of the empire in Africa in 1904.

<sup>485</sup> Schneider's article provides a table of smallpox cases and vaccinations in Cameroon from 1925-1957. 223.

<sup>486</sup> France, *Rapport du Gouvernement français à l'Assemblée générale des Nations Unies sur l'administration du Cameroun place sous la tutelle de la France* (1951), 235. France, *Rapport du Gouvernement français à l'Assemblée générale des Nations Unies sur l'administration du Cameroun place sous la tutelle de la France* (1951), 240. It should also be noted that the accuracy of colonial statistics on disease is highly questionable and these numbers most likely represent an under-reporting of disease cases. See: William H. Schneider, "Smallpox in Africa during Colonial Rule," *Medical History* 53 (2009): 195.

teams examined 298,222 people and 231,850 of those were given a smallpox vaccination.<sup>487</sup>

Smallpox vaccination thus became one of the primary interventions of the mobile health teams, and helped to control the relatively infrequent epidemics in Cameroon.<sup>488</sup>

Throughout the colonial period and the last stretch of the smallpox eradication campaign, the concentration of cases of smallpox largely occurred in the far northern region of Cameroon, an area bordered on one side during the colonial period by British Cameroon and on the other by Chad. After independence, this part of British Cameroons became part of Nigeria and demarcated a national border with Cameroon. For people living in northern Cameroon, particularly those living in the Mandara mountains, smallpox had long represented a fearsome force, striking communities in memorable episodes of disease retained in oral tradition.<sup>489</sup> One anthropologist of northern Cameroon described the impact of smallpox epidemics on communities as “opening a parenthesis in time,” suspending all social and economic activity.<sup>490</sup> Communities across the northern region had in turn developed varied approaches to addressing

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<sup>487</sup> France, (1951), 231.

<sup>488</sup> Schneider, 203. William Schneider has argued that the WHO institutional history (Fenner et al.) has been taken as the ‘last word’ on the smallpox eradication program, but points out that it does not consider the history of vaccination campaigns in Africa before the eradication program. William H. Schneider, “Smallpox in Africa during Colonial Rule,” *Medical History* 53 (2009): 193-227. William H. Schneider, “The Long History of Smallpox Eradication: Lessons for Global Health in Africa,” in *Global Health in Africa: Historical Perspectives on Disease Control*, ed. Tamara Giles-Vernick and James L.A. Webb Jr. (Athens: Ohio University Press, 2013): 25-41.

<sup>489</sup> Oral traditions recorded in 1995 in the region told of 7-8 major epidemics: 1866-1867, around 1890, 1904-1906, 1914-1915, 1929-1933, 1943-1944, 1951-1952, 1961-1962. Christian Seignobos, « La variole dans le Nord-Cameroun: Représentation de la maladie, soins et gestion sociale de l'épidémie, » *Cahier des Sciences humaines* 31, 1 (1995) : 150. French colonial archives record mark epidemics similarly from 1929-1931, slightly earlier in 1940, 1944-1947 and around 1952-1954. See Schneider 2009, 223. Seignobos also notes the various names for smallpox used by people in the area, translating to ‘the big thing’ from Fulfulde or ‘the fire of God’ among the Mofu Duvangar, 149.

<sup>490</sup> Seignobos, 149.

the disease, including prevention of its spread through inoculation and regimented practices of care, through isolation and other means, for those who fell ill.<sup>491</sup>

The mobility of people in this area, rooted in a deep regional history, facilitated the spread of smallpox. The cross-border region shared a history rooted, in part, in the consolidation of the Sokoto caliphate, the spread of Islam and of Fulbe political dominance in the nineteenth century. Although European colonial powers demarcated borders across this space at the end of the 19<sup>th</sup> century, it remained a place heavily demarcated as well by indigenous African political formations and networks of trade.

French colonial officials treated mobility, both in this area and more broadly across the colonies, as a challenge to governance and something to seek to counteract. Beginning in the late 1920s, for example, the colonial government had pursued a ‘regroupement’ policy for some communities in the Department of Adamawa, seeking to stabilize people into newly formed villages that could then be administered in accordance with French needs for labor and tax collection.<sup>492</sup> Historians have noted, however, ways in which people might use mobility as a “political strategy and means of dispute regulation.”<sup>493</sup> People might use the border, for example, to economic ends, as in 1958 when 150 people crossed over from British Cameroon to settle in French Cameroon in search of a lower tax requirement.<sup>494</sup> This movement was

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<sup>491</sup> The specificity and variation of these practices is explained in great detail by Seignobos, 153-170. He notes that inoculation was practiced only in some places, often not in a systematic way.

<sup>492</sup> Philip Burnham, “‘Regroupement’ and Mobile Societies: Two Cameroon Cases,” *The Journal of African History* 16 no.4 (1975): 577-594. Burnham’s article focuses on the Gbaya and the pastoral Fulani of Adamawa.

<sup>493</sup> Burnham, 594.

<sup>494</sup> NAC 2AC 7117, *Subdivision de Mokolo, Rapport Politique Trimestriel, 1<sup>er</sup> Trimestre 1958*. This report also notes the political uncertainty at this time about the fate of the British Cameroons. Some people from that territory anticipated in 1958 that their territory would eventually be attached to that of French Cameroon with independence.

facilitated both by a lack of firm border control and the networks created by historical ties of trade, language and custom.<sup>495</sup> One colonial administrator in northern Cameroon mused in 1958 that the trucks and donkeys crossing the border moved, not only fabrics and kola nuts, but also ideas; that the movement of merchants and farmers maintained a tight network of information across the neighboring territories. He observed that in their ‘spirit,’ the towns of Mokolo and Mora had more in common with areas just across the border than with those in southern Cameroon.<sup>496</sup> He observed that this cross-border unity might pose a potential challenge to future national unity within Cameroon.

Colonial health officials similarly worried that people could use the border to avoid vaccination. In 1945, colonial officials corresponded about setting up a meeting between the Directors of Health in French Cameroon and Nigeria in order to coordinate vaccination campaigns, in the hopes that this would prevent people from crossing the border to escape vaccination.<sup>497</sup> Yet despite some efforts at cross-border coordination, vaccination schedules and planning proceeded largely within the bounds of colonial territories. Throughout the colonial period and through the 1960s, health officials in Cameroon in turn framed the problem of smallpox in the state largely as one of cases “imported” across the Nigerian border.<sup>498</sup>

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This ended up being the case for the southern British Cameroons, but the northern territory became part of independent Nigeria.

<sup>495</sup> NAC 2AC 7117, *Etat du Cameroun, Région du Margui-Wandala, Rapport Annuel 1958*, 4. This report observed that there was not efficient policing of customs procedure at the border of this region.

<sup>496</sup> NAC 2AC 7117, *Etat du Cameroun, Région du Margui-Wandala, Rapport Annuel 1958*, 4.

<sup>497</sup> NAC APA 10909/K.

<sup>498</sup> The idea of “imported case” points to a broader trend in colonial Africa. Schneider notes that colonial health reports across the European powers in Africa often described any smallpox epidemic in their colonies as originating from another colony, 206. The cases of smallpox that did appear in OCEAC countries during the

After independence in 1960, the *Service des Grandes Endémies* in East Cameroon adopted a triennial schedule for smallpox vaccination, meaning that the goal would be for mobile teams to vaccinate the entire population over the course of every three years.<sup>499</sup> The first major outbreak of smallpox occurred after independence in northern Cameroon in 1961-1962. The first smallpox cases appeared in 1961 in the northern British Cameroons, which would become part of independent Nigeria in that same year.<sup>500</sup> People traveling from the area to the administrative department of Margui-Wandala in Cameroon spread the disease to several people there.

French military doctor, André Delas, who oversaw the mobile health service around Maroua in the early 1960s during this epidemic, spoke about the frequent travel of people in the region as a source of difficulty in controlling the epidemic.<sup>501</sup> Health officials attempted to implement prohibition against travel by the sick but cases nonetheless cropped up in Maroua and Kaélé. Medical officials reported that one person sick with smallpox had traveled to Kaélé by truck at night.<sup>502</sup> Here, in direct contrast to the celebrated mobility of the vaccination teams, the mobility of individuals outside of the biomedical infrastructure was cast as a problem.

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smallpox program from 1967-1969 were in turn almost always attributed to movement of people across the Nigerian border. Frank Fenner et al, *Smallpox and its Eradication* (Geneva: World Health Organization), 1988, 907

<sup>499</sup> *Rapport Final de la Premier Conférence Technique de l'OCCGEAC* Yaoundé du 7 au 11 Décembre 1965, Tome II, 263.

<sup>500</sup> People of the British Cameroons voted by referendum in 1961 about whether to become politically joined with Nigeria or with former French Cameroon. The people of the northern British Cameroons voted to join Nigeria and those of the southern area to join the former French Cameroon in the creation of a Federal Republic.

<sup>501</sup> A. Delas and J. Roguet, « A Propos D'une Epidémie de Variole au Nord-Cameroun (1961-1962), » *Médecine Tropicale : Revue du Corps de Santé Colonial* Vol. 23, No. 1 (1963) : 114.

<sup>501</sup> Delas and Roguet, (1963), 115.

<sup>502</sup> Delas and Roguet, (1963), 114.



Travel was just one of the actions blamed for the spread of smallpox. Delas also attributed its spread to hostility to vaccination among the population, and among those who were vaccinated, the practice of rubbing the site of the vaccine with soil, lemon juice or tamarind to try to neutralize its effect.<sup>503</sup> This practice extended to other areas of northern Cameroon. When a smaller outbreak of smallpox occurred further south in Rey-Bouba around the same time, a national newspaper warned during the outbreak that individuals attempting this cleaning after the vaccine would face a “severe penalty” and that “naïve” reasons for refusing vaccination would not be tolerated by authorities.<sup>504</sup>

During the epidemic, Delas and other medical officials realized, however, that a significant number of the smallpox cases were among people who had just recently been vaccinated. After conducting an experiment in Maroua, vaccinating half of the people with the existing vaccine, supplied by the Institut Pasteur de Kindia (Guinea) and half with a vaccine supplied by the Institut Pourquier de Montpellier (France), Delas concluded that the efficacy of the vaccine from Kindia had been compromised, possibly due to problems with proper transport and storage.<sup>505</sup> People living in northern Cameroon had thus been vaccinated against smallpox but then contracted the disease anyway, thereby greatly undermining health officials’ insistence on having a biomedical solution to the disease that should be fully embraced. Over 500,000 people had been vaccinated with a vaccine of questionable efficacy.

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<sup>503</sup> Delas and Roguet, (1963), 114.

<sup>504</sup> NAC *La Presse du Cameroun*, No. 3588 Vendredi 6 Avril 1962, « Epidémie de variole et disette dans le Rey-Bouba, » 1.

<sup>505</sup> Delas (1963), 115-116.

This kind of occurrence could have repercussions for vaccination campaigns in communities for years to come. In 1965 for example, a Cameroonian government official reported from Guider that a smallpox vaccination campaign had provoked a “massive exodus” in the administrative district of Douma. He reported that, while local politics might have been at play, that the consequences of the fear that the population experienced in 1962 after a vaccination campaign that resulted in multiple deaths could not be discounted.<sup>506</sup>

After the main outbreak in the far north of Cameroon, however, the reported cases of smallpox in Cameroon remained very low, going from 1145 cases in 1961 to only 28 in 1965.<sup>507</sup> When American officials announced funding for the smallpox and measles program in West and Central Africa in 1965, health officials in Cameroon did not, therefore consider smallpox to be a top public health priority. Other OCEAC member countries likewise did not face a large number of smallpox cases by the time of the start of the eradication program (Table 2). The disease still, however, represented a threat more broadly across West Africa. Bordering Nigeria, for example, had almost three-fourths of the cases of the smallpox in the region in 1965.<sup>508</sup> In this context, the planning for the program ultimately raised fundamental questions about the role of the mobile teams in the first major disease eradication program after independence, the role of Americans showing up in Yaoundé with their own bold new ideas, and the salience of the OCEAC framework for regional health coordination.

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<sup>506</sup> NAC 1 AA 502 Nord Cameroun, *Département de la Bénoué, Préfecture de Garoua, Rapport Politique Trimestriel, Janvier, Février, Mars, Avril, Jun 1965*, 8.

<sup>507</sup> Frank Fenner et al. *Smallpox and its Eradication* (Geneva: World Health Organization. 1988): 907.

<sup>508</sup> Frank Fenner et al, 857.

**Table 2****OCEAC member states, number of reported cases of smallpox, 1961-1969**

Year	Cameroon	Central African Republic	Chad	Congo	Gabon
1961	1145	0	502	23	0
1962	743	57	769	1254	1
1963	135	3	10	1476	111
1964	88	0	5	198	49
1965	28	0	73	89	1
1966	2	0	0	0	0
1967	119	0	86	0	0
1968	37	0	5	0	0
1969	3	0	0	0	0

Source: Frank Fenner, et al. *Smallpox and its Eradication* (Geneva: World Health Organization), 1988, 907.

**Smallpox Eradication and OCEAC**

American officials attended the first technical conference of the *Organisation de Coordination pour la lutte contre les Endémies en Afrique Centrale* (OCEAC) in Yaoundé in 1965 to present the proposal for the smallpox eradication and measles control program in West and Central Africa. Because planning for the program began at OCEAC's first technical conference, it was not merely an outside program being pitched to a long-standing organization but was rather a formative event in OCEAC defining its work and positioning vis a-vis other health organizations. In Yaoundé, the initiation of the smallpox eradication program created an opening for OCEAC to assert itself as a regional health actor as it navigated direct American engagement with the organization. It also raise questions about what this new avenue of resources for vaccination meant for the functioning of the mobile health teams in OCEAC member states.

In their capacity of the leadership of OCEAC, Dr. Jean-Claude Happi of Cameroon<sup>509</sup>, acting President of the organization, and French Secretary General, Dr. René Labusquière, asserted the solidarity of OCEAC states in their health cooperation and the centrality of their operations to the smallpox program. By asserting OCEAC as a forum for interaction with the American CDC, Happi and other African officials upheld both their regional relationships and ties to France as a framework for their engagement with other international health programs. Labusquière and other French doctors meanwhile secured their ongoing place through OCEAC as brokers of international health programs operating in Cameroon and other OCEAC states. Finally, seen from the vantage point of OCEAC, the smallpox program represented an influx of resources that could revitalize the work of the mobile health teams in the member states.

The original American proposal for the smallpox program challenged OCEAC's regional framework for health coordination and thus set off immediate controversy. The proposal raised fundamental questions about the purpose of OCEAC as a coordinating body of member states. On December 9<sup>th</sup>, Dr. Clayton Curtis, Medical Director of the Africa Bureau of USAID<sup>510</sup> presented the general proposal for the smallpox/measles program to the OCEAC conference.<sup>511</sup> Curtis presented the US proposal for five years of aid starting in July 1966 “in

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<sup>509</sup> Happi had been named ‘Commissaire général à la santé publique et à la population’ of Cameroon in May 1965. *Personnalités publiques de l'Afrique centrale 1968*, (Paris : Ediafric, 1968). Numéro spécial de bulletin de l'Afrique noire.

<sup>510</sup> The other US representatives at this meeting were D.A. Henderson, Henry Gelfand of the CDC, and Dr. Warren Winkelstein, a CDC consultant. *Rapport Final de la Première Conférence Technique de l'O.C.C.G.E.A.C.*, Yaoundé du 7 au 11 Décembre 1965, Tome I, 3. In the report, the entire delegation is listed under the heading ‘US/A.I.D.’ Horace G. Ogden, *CDC and the Smallpox Crusade* (Atlanta, GA : U.S. Department of Health and Human Services, Public Health Services, Centers for Disease Control, 1987), 26.

<sup>511</sup> Curtis first presented the program to the whole OCEAC conference and then to a smaller subcommittee. The smaller subcommittee meeting involved the directors of the national mobile health services (SGE) of the national health services, Dr. Loembe as representative of Congo-Brazzaville, the French doctors of the Secretariat General of OCEAC, the USAID/CDC delegation to the meeting. Dr. Loembe was the ‘Directeur des Affaires Sociales’ for the Republic of Congo-Brazzaville and was attending the OCEAC conference, along with the Minister of Public

18 African countries, going from Mauritania to Gabon.”<sup>512</sup> He offered the list of included countries, however, without commentary on the exclusion of a member state of OCEAC, Congo-Brazzaville, from the program.<sup>513</sup> Driven by Cold War politics, the United States had suspended formal diplomatic ties with the country in August 1965.<sup>514</sup> After the presentation of the proposal, Dr. Loembe of Congo-Brazzaville announced his ‘legitimate emotion’, as a representative of his government, at discovering that his country had been excluded from the proposal while the other states of OCEAC were included, given that the program was being presented in the forum of the organization.

When the conference revisited the topic, Labusquière and Happi first struck a conciliatory tone, suggesting ways that the smallpox program could proceed and working to

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Health, as part of the delegation for the country. A representative of the mobile health team service for the country was notably not in attendance.

<sup>512</sup> *Rapport Final de la Première Conférence Technique de l’O.C.C.G.E.A.C.*, Yaoundé du 7 au 11 Décembre 1965, Tome II, 330. Countries included: Cameroon, Central African Republic, Chad, Dahomey, Gabon, Gambia, Ghana, Guinea, Ivory Coast, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Togo and Upper Volta. Note : The remarks of Dr. Curtis were translated from English to French for inclusion in the report. I am providing my own translations back into English here.

<sup>513</sup> Warren Winkelstein noted after the conference that this lack of explanation was a mistake “In retrospect it would appear that it would have been far better to include a brief statement of the reason for excluding the Republic of Congo when the program was presented by Dr. Curtiss. (sic) While this would not have avoided the objections of the Republic of Congo, it would have made our position much stronger since we would have acknowledged the real reason for excluding this country. As it was, we were placed in the awkward position of insisting that the exclusion was based on financial and epidemiological reasons, which was obviously not the case.” The National Archives at Atlanta, RG 442-CL-06-33-02, Box 3, Folder 21, “Memorandum, Subject: O.C.C.G.E.A.C. Conference-Discussion of U.S. Smallpox Eradication/Measles Program at Final Session” To: D.A. Henderson and H. Gelfand, From: W. Winkelstein, Jr., Douala, Abidjan: 12 December 1965.

<sup>514</sup> An uprising in August 1963 overturned the regime of Congo’s first President, Fulbert Youlou. Alphonse Massamba-Debat was elected president and a new Marxist-Leninist party, the *Mouvement National de la Révolution* was created. Elikia M’Bokolo, “Comparisons and contrasts in equatorial Africa: Gabon, Congo and the Central Africa Republic,” in *History of Central Africa: the Contemporary Years Since 1960*, ed. David Birmingham and Phyllis M. Martin. (London: Addison Wesley Longman Limited, 1998), 81-82. Diplomatic ties with the United States remained suspended from 1965-1977. United States Department of State, Office of the Historian, “A Guide to the United States’ History of Recognition, Diplomatic, and Consular Relations, by Country, since 1776: Republic of the Congo,” Accessed June 1, 2016. <https://history.state.gov/countries/congo-republic>.

define OCEAC's newly created role. In their comments, the doctors evoked images of OCEAC as both a geographic entity and one tied together by relational bonds. Labusquière lamented that the US funding proposal "passed through the middle of OCEAC."<sup>515</sup> Dr. Happi conceded that OCEAC could not support this position to exclude one member of the "fraternal organization."<sup>516</sup> Yet both also sought to reconcile the controversy, with Labusquière suggesting that OCEAC could offer assistance to Congo-Brazzaville<sup>517</sup> and Happi quickly suggesting that perhaps the program could be established on a bilateral basis with each state.<sup>518</sup> These suggestions—one positioned to strengthen and the other to weaken OCEAC's regional coordinating role—marked a moment of uncertainty in how the organization would deal with new actors and Cold War politics.

The representatives of Congo-Brazzaville, however, insisted upon the need for OCEAC to stand its ground against the US proposal. Mr. Simon Gokana,<sup>519</sup> Minister of Public Health for Congo, "expressed his discontent," saying that "OCEAC not being a political organization, it is regrettable to see the United States bring a political feud into the heart of OCEAC and to see OCEAC accept this fact. If the member states of OCEAC accept the proposal of the United

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<sup>515</sup> *Rapport Final de la Première Conférence Technique de l'O.C.C.G.E.A.C.*, Yaoundé du 7 au 11 Décembre 1965, Tome II, 566.

<sup>516</sup> The National Archives at Atlanta, RG 442-CL-06-33-02, Box 3, Folder 21, "Memorandum, Subject: O.C.C.G.E.A.C. Conference-Discussion of U.S. Smallpox Eradication/Measles Program at Final Session" To: D.A. Henderson and H. Gelfand, From: W. Winkelstein, Jr., Douala, Abijan: 12 December 1965.

<sup>517</sup> *Rapport Final de la Première Conférence Technique de l'O.C.C.G.E.A.C.*, Yaoundé du 7 au 11 Décembre 1965, Tome II, 566.

<sup>518</sup> The National Archives at Atlanta, RG 442-CL-06-33-02, Box 3, Folder 21, "Memorandum, Subject: O.C.C.G.E.A.C. Conference-Discussion of U.S. Smallpox Eradication/Measles Program at Final Session" To: D.A. Henderson and H. Gelfand, From: W. Winkelstein, Jr., Douala, Abijan: 12 December 1965.

<sup>519</sup> Gokana was trained as a nurse and served as the Minister of Public Health, Population and Social Affairs from April 1965-January 1968: *Personnalités publiques de l'Afrique Centrale*. Numéro spécial de Bulletin de l'Afrique Noire. (Paris, Ediafric, 1968), 237.

States, Congo will be forced to withdraw from the organization.”<sup>520</sup> Dr. Loembe reiterated the need for pooling the efforts of the member states and that it was difficult to see that his country would be left out of a vaccination plan. He insisted that OCEAC express its displeasure to USAID to see “discrimination done for punitive reasons.” He warned of the danger of creating this precedent as a threat to the future of the organization.<sup>521</sup>

This controversy thus became a defining moment in OCEAC negotiating the parameters and limits of the cooperation of member states, and its dealing with external organizations. Dr. Aujoulat, attending the meeting with the French delegation<sup>522</sup>, pushed the issue, posing the question whether the best course of action would be for OCEAC to reject, as a group, the American aid if it did not extend to all of the member states, ‘the raison d’être of OCEAC being to affirm the total solidarity of the states who compose it.’<sup>523</sup> This proposal notably would concern not just the smallpox campaign money being offered, but also aid that had already been extended to three countries for measles vaccinations.<sup>524</sup> Minister Gokana added that he did not want the other states of OCEAC to refuse American aid for reasons concerning his country, but

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<sup>520</sup> *Rapport Final de la Première Conférence Technique de l’O.C.C.G.E.A.C.*, Yaoundé du 7 au 11 Décembre 1965, Tome II, 567.

<sup>521</sup> *Rapport Final de la Première Conférence Technique de l’O.C.C.G.E.A.C.*, Yaoundé du 7 au 11 Décembre 1965, Tome II, 567.

<sup>522</sup> Dr. Aujoulat’s position at this time was ‘Directeur du Centre National d’Éducation Sanitaire et Sociale, et de la Coopération Technique au Ministère de la Santé Publique’ for France. The other member of the French delegation was Dr. Vernier, ‘Adjoint au Directeur de la Coopération Culturelle et Technique, Représentant du Ministère de la Coopération. »

<sup>523</sup> *Rapport Final de la Première Conférence Technique de l’O.C.C.G.E.A.C.*, Yaoundé du 7 au 11 Décembre 1965, Tome II, 568.

<sup>524</sup> The National Archives at Atlanta, RG 442-CL-06-33-02, Box 3, Folder 21, “Memorandum, Subject: O.C.C.G.E.A.C. Conference-Discussion of U.S. Smallpox Eradication/Measles Program at Final Session” To: D.A. Henderson and H. Gelfand, From: W. Winkelstein, Jr., Douala, Abijan: 12 December 1965. This referred to support previously extended to Cameroon, Chad and the Central African Republic for measles control.

that because OCEAC was not political and the American offer was being only partial, it should not have been negotiated here. He requested that negotiations take place outside of OCEAC. Dr. Happi assured the Minister that “OCEAC had learned of the plans of USAID at the same time as everyone, and with as much surprise. There were no previous negotiations on the subject.”<sup>525</sup>

The conference attendees concluded the issue by adopting a resolution calling for a deferment of the US-backed program until a solution could be found to ensure provision of vaccines for all of the member states of OCEAC and to ensure that all of the states would benefit from the plan. The resolution called for OCEAC to pursue negotiations with USAID in order to sort out the issues raised at the conference. The resolution further called, based on a request by Minister Gokana, for those member states already having finalized bilateral agreements with USAID, to continue to pursue those operations.<sup>526</sup> Dr. Happi was charged with consulting on this recommendation with the ministers of health of the member states.<sup>527</sup> In his remarks closing the conference, Dr. Happi asserted the formation of OCEAC as a bloc of states:

We sincerely thank Doctor Curtis and his colleagues for the offer by their country and we ask them to relay the expression of our gratitude to their government. But we would like them to take this opportunity to remind this government that OCEAC is constituted by five states fraternally united

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<sup>525</sup> *Rapport Final de la Première Conférence Technique de l'O.C.C.G.E.A.C.*, Yaoundé du 7 au 11 Décembre 1965, Tome II, 568.

<sup>526</sup> *Rapport Final de la Première Conférence Technique de l'O.C.C.G.E.A.C.*, Yaoundé du 7 au 11 Décembre 1965, Tome II, 575-576.

<sup>527</sup> The United States representatives spoke privately with Dr. Happi after the meeting ‘to express our regret that the U.S. proposal had introduced a discordant note in the first technical meeting’ of the organization. They reported that Dr. Happi ‘did not seem particularly upset by the situation,’ nor did Dr. Labusquière. But Happi turned his attention after the meeting to talking with Dr. Loembe to smooth over the situation. According to the US delegate, ‘Dr. Aujoulat’s action had been designed to ameliorate the entire situation. Furthermore, other delegates agree that while the matter was serious, it was unlikely to eventuate in the Republic of Congo actually withdrawing’ from OCEAC. The National Archives at Atlanta, RG 442-CL-06-33-02, Box 3, Folder 21, “Memorandum, Subject: O.C.C.G.E.A.C. Conference-Discussion of U.S. Smallpox Eradication/Measles Program at Final Session” To: D.A. Henderson and H. Gelfand, From: W. Winkelstein, Jr., Douala, Abidjan: 12 December 1965.



in the fight against major diseases and it hopes that the generous assistance plans may be extended, without distinction, to all of these five countries. If OCEAC was a mother, how would she accept that one of her children starve to death, while the other four eat their fill? OCEAC would have a guilty conscience sponsoring such a division. It might be useful in order to guard the fundamental principle of cohesion of our organization to leave the backing of such aid to the states themselves.<sup>528</sup>

This issue thus raised fundamental questions about the role of OCEAC as a regional health actor at a key moment of self-definition for the organization. And it was through the arrangements created through the smallpox program that the organization most clearly carved out this role.

Ultimately, it was OCEAC leadership that secured funding of the smallpox program for Congo-Brazzaville and it was the existence of the organization as an intermediary that made this arrangement politically possible for US agencies. American officials continued to negotiate this issue with Labusquière and Happi throughout the winter and spring of 1966. On January 4, 1966, the United States Ambassador to Cameroon, Leland Barrows, sent a letter to Dr. Happi, relaying the willingness of the United States government to reach an agreement with OCEAC to include all the member states in the vaccination program. The letter laid out a precondition for this agreement: “In the case where the personnel of the United States are not able to participate in the execution of the program, special technical and administrative arrangements for the running of the program must be assured by OCEAC.”<sup>529</sup> This letter set OCEAC in motion

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<sup>528</sup> *Rapport Final de la Première Conférence Technique de l'O.C.C.G.E.A.C.*, Yaoundé du 7 au 11 Décembre 1965, Tome II, 580.

<sup>529</sup> My translations from French, The National Archives at Atlanta, RG 442-CL-06-33-02, Box 3, Folder 21, Yaoundé le 4 Janvier 1966, L'Ambassadeur des Etats Unis d'Amérique auprès de la République Fédérale du Cameroun à Monsieur le Commissaire General à la Santé Publique et à la Population de la République Fédérale du Cameroun à Yaoundé. CC : Dr. Labusquiere (sic), Secrétaire Général de l'OCCGEAC ; AID : F.J. Lapinski, AID Affairs Officer.

towards setting up a plan for a program in Congo-Brazzaville in order to be able to move forward on signing a direct agreement with the United States.<sup>530</sup>

The importance of the position that OCEAC took on the subject appeared in the background diplomatic coordination being conducted by US officials. Dr. George Lythcott, the Director of the CDC regional program office, met with Ambassador Barrows on February 18, 1966 and discussed a plan put forth to make the Congo-Brazzaville program operational in Fiscal Year 1968, a one year lag from the other OCEAC countries. The Ambassador made it clear that if Dr. Labusquière of OCEAC and Cameroonian officials accepted this plan that he would also support it, “however if either did not accept the arrangement, that he, too, would insist that all five countries becoming (sic) operation at the same time.” Barrows had originally taken the position that Congo-Brazzaville should be added to the original 18 country plan. Lythcott subsequently met with Dr. Labusquière on March 2<sup>nd</sup> and the OCEAC Secretary General ultimately did insist that all five OCEAC countries become operational at the same time.<sup>531</sup> Lythcott received word back from Dr. Curtis that USAID was willing to supply vaccine and equipment for Congo-Brazzaville only through OCEAC, and that any technical assistance would have to be provided by non-US staff, be it OCEAC or WHO.<sup>532</sup> In the context of the Cold War and post-independence Central African politics, it was thus through the smallpox

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<sup>530</sup> The National Archives at Atlanta, RG 442-CL-06-33-02, Box 3, Folder 21, Yaoundé le 11 Janvier 1966, Le Médecin Lieutenant Colonel Labusquière Secrétaire Général de l'OCCGEAC à Monsieur le Docteur Henry M. Gelfand, Communicable Disease Center.

<sup>531</sup> The National Archives at Atlanta, RG 442-CL-06-33-02, Box 3, Folder 21, “Discussions with Ambassador Barrows (Cameroun)” To: Dr. D.A. Henderson, Dr. H.M. Gelfand, Dr. R.H. Henderson, From: Dr. George Lythcott., Yaoundé, March 3, 1966. This memo also details Ambassador Barrow’s frustration at being ‘second-guessed and ignored by Washington (AID and State) in decisions affecting his areas of responsibility,’ given his original position that Congo-Brazzaville need to be included in the program for Fiscal Year 1967.

<sup>532</sup> The National Archives at Atlanta, RG 442-CL-06-33-02, Box 3, Folder 21, Cablegram, Department of State, Unclassified, ‘Smallpox Measles Program,’ Drafted by A.C Curtis, pass to Lythcott, March 9, 1966. (Pic P1020196)

program that OCEAC, African health ministers, and the American CDC and USAID forged new operational relationships of international health.

As these negotiations continued, discussion also developed about how exactly the smallpox program would operate in OCEAC countries. Dr. Happi and Dr. Labusquière both asserted in these planning stages that the smallpox program would not operate independently from the work of the mobile health teams of OCEAC member states, but would rather be folded into their regular work. This conception of the program differed from that of the CDC, which advocated for the creation of special vaccination teams.<sup>533</sup> Happi and Labusquière's stance both asserted existing mobile health service infrastructure as a necessary point of entry for international disease campaigns and successfully leveraged the resources offered through the program, particularly that of vehicles, in service of the mobile teams.

Dr. Happi and Dr. Labusquière laid out these proposed operations to US representatives in February of 1966. In a letter accompanying a proposed 'Five-year plan of vaccination,' Dr. Happi wrote to the USAID representative in Yaoundé, "We are in fact anxious that these vaccinations as is normal form a part of the usual multiple activity of the major Endemic Diseases Services without there being specialized teams for this or that vaccination. This doubtless entails the necessity for more supplies since each team would need to be supplied, but on the other hand a saving in personnel and operating expenses. And for the States..[OCEAC].. such an economy is of first importance." <sup>534</sup>

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<sup>533</sup> Horace G. Ogden, *CDC and the Smallpox Crusade* (Atlanta, GA: U.S. Department of Health and Human Services, Public Health Services, Centers for Disease Control, 1987), 62. This CDC institutional history also explains the important difference of 'operational philosophy' with OCEAC on the need for assessment and surveillance following mass vaccination.

<sup>534</sup> The National Archives at Atlanta, RG 442-CL-06-33-02, Box 3, Folder 21, Letter To: The Representative, USAID, Yaoundé, From: President, OCCGEAC, Yaoundé, Subject: Five-year plan of vaccination, February 28, 1966. English translation of original letter.

The OCEAC vaccination plan also sought to coordinate aid from USAID, from the French Fund for Aid and Cooperation (FAC) and from UNICEF into one operational structure. The operations plan thereby sought to coordinate vaccinations against measles and smallpox, as well as against yellow fever and tuberculosis, arguing that “in this manner, the same vehicles and the same means of refrigeration will allow the transportation of different vaccines and the same equipment will be utilized simultaneously for the inoculation of vaccines from different sources.”<sup>535</sup> In addition to the measles and smallpox vaccine provided by the US, OCEAC anticipated the provision of tuberculosis vaccine through the French Government and of yellow fever vaccine through UNICEF. From the US, OCEAC also requested the provision for each mobile team with equipment comprising the Ped-O-jet<sup>536</sup> for vaccination, a portable refrigerator for vaccine transport, a freezer for vaccine preservation at central points, and means of transportation for the teams.<sup>537</sup> Each country submitted specific requests to OCEAC about the needs for these equipment from the US, which OCEAC then submitted as a comprehensive plan. OCEAC also requested materials, including Ped-O-Jets and freezers, for use in its training program for mobile health team personnel based in Yaoundé.<sup>538</sup> OCEAC thus approached the initiation of the smallpox/measles program as a way to bolster the overall work of the mobile

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<sup>535</sup> The National Archives at Atlanta, RG 442-CL-06-33-02, Box 3, Folder 21, Memo, From: OCCGEAC, Subject: Operations plan for vaccination campaigns, February 28, 1966. The plan laid out different vaccination schedules for each OCEAC country, either on annual, biennial or triennial schedules. Cameroon, for example, proposed a triennial schedule, such that all of the population was vaccinated every 3 years.

<sup>536</sup> The jet injector was a new means of vaccination developed in the 1960s and made it possible to vaccinate people much more quickly with fewer medical personnel. Ogden, 11.

<sup>537</sup> The National Archives at Atlanta, RG 442-CL-06-33-02, Box 3, Folder 21, Memo, From: OCCGEAC, Subject: Operations plan for vaccination campaigns, February 28, 1966. The plan called for freezers at each ‘sector base’ of the mobile health teams. Each country was divided into administrative sectors for the organization of the mobile teams.

<sup>538</sup> The National Archives at Atlanta, RG 442-CL-06-33-02, Box 3, Folder 21, Memo, From: OCCGEAC, Subject: Operations plan for vaccination campaigns, February 28, 1966.

health teams by improving their equipment in the form of vehicles, freezers, and the provision of vaccines. Dr. Happi characterized the aid provided through the smallpox program as “truly considerable” and as something that would enable the realization of the “vocation” of OCEAC through “une action mobile, sociale, preventive et simultanée dans tous les Etats Membres...”<sup>539</sup> OCEAC member states were ultimately the only countries in the US-funded West and Central African smallpox/measles program to fully incorporate the program into their existing medical services.<sup>540</sup>

Enthusiasm for the goal of smallpox eradication itself was muted among OCEAC leadership and members. Dr. Lythcott of the CDC reported in March 1966 that “preliminary discussion with Labusquière speaking for all OCEAC countries this morning strongly suggests he does not accept concept of smallpox eradication” and that the decision to not mount special vaccination teams for smallpox reflected this stance.<sup>541</sup> Labusquière’s stance reflected a pride and defensiveness about the previous French-led efforts to control smallpox in the member states. Leading up to the launch of the official smallpox program, he emphasized that the program would only “consolidate, thanks to material resources never equaled, the results

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<sup>539</sup> OCEAC Archives, *Rapport Final de la Deuxième Conférence Technique de L’O.C.E.A.C. Yaoundé du 30 Janvier au 3 Février 1967* Tome I, 10.

<sup>540</sup> Fenner, F. et al. *Smallpox and its Eradication* (Geneva: World Health Organization), 1988, 866. Table 17.3. Upper Volta used existing prospection teams for smallpox vaccination but created special teams for measles vaccination. All other countries created special teams for smallpox and measles vaccination. On a more local level of experiencing this campaign, the lack of special teams and the combination of vaccination deserves note. From this vantage point, the smallpox eradication program may have been nothing remarkable at all in many of its local iterations. That is to say that particularly in places that had not seen smallpox cases in many years, the campaign would be carried out, not by foreigners, but by Cameroonians or Chadians, etc in mobile teams, which had been carrying out vaccinations for decades. The visitation of mobile teams to rural communities for vaccination was therefore not of note in itself, although the histories of those interactions widely varied across and within OCEAC states.

<sup>541</sup> The National Archives at Atlanta, RG 442-CL-06-33-02, Box 3, Folder 21(Cablegram?) Department of State, Unclassified, For Dr. Henderson and Gelfand USPHS Atlanta, GA, From Lythcott, March 1, 1966.

already obtained through many years of effort.”<sup>542</sup> While the American CDC touted the promise of the Ped-O-Jet to facilitate eradication efforts, Labusquière insisted that eradication depended less on technique or the vaccine used and more on levels of absenteeism at vaccination sessions; he insisted that eradication was primarily an administrative or governmental question.<sup>543</sup> In addition to doubting the feasibility of smallpox eradication, Labusquière approached the new incursion of Americans into OCEAC countries, and more broadly into medical work in Africa, with considerable skepticism.<sup>544</sup>

African health ministers and doctors of OCEAC framed the problem of smallpox, and their investment in the eradication program, as being related to an external rather than an internal problem. Dr. Happi voiced support for the program in terms of controlling smallpox, but thought the goal of eradication and the ten-year timeline to do so proposed by the World Health Assembly might be “too hasty,” particularly in light of the failure of malaria eradication.<sup>545</sup> He spoke instead about the factors necessary for smallpox control and characterized the problems that Cameroon faced in this regard as being due to re-introduction of the disease from neighboring countries. Happi argued that coordination between countries

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<sup>542</sup> OCEAC Archives, *Activité des Services des Grandes Endémies Des Etats-Membres, Synthèse Globale, Rapport Annuel 1966*, O.C.E.A.C, 66.

<sup>543</sup> *Rapport Final de la Première Conférence Technique de l'O.C.C.G.E.A.C.*, Yaoundé du 7 au 11 Décembre 1965, Tome II, 287.

<sup>544</sup> Sencer, David (Interviewer); CDC; Former Director of CDC, “Jeannie Lythcott Oral History,” The Global Health Chronicles, accessed March 17, 2016, <http://www.globalhealthchronicles.org/items/show/3493>. Jeannie Lythcott, wife of George Lythcott, remembers Labusquière as being ‘just puffed up with national pride. Any notions that Americans were going to be coming to help them were just impossible.’ Other CDC officials made similar observations about their interactions with French doctors across West and Central Africa over the course of the program. See: Harden, Victoria (Interviewer), “Christopher D'Amanda Oral History,” The Global Health Chronicles, accessed March 16, 2016, <http://www.globalhealthchronicles.org/items/show/3489>.

<sup>545</sup> WHO AFR/RC 16/11 Rev. 1, World Health Organization Regional Office for Africa, *Sixteenth Session of the WHO Regional Committee for Africa, Held in Kinshasa, Democratic Republic of the Congo from 12 to 22 September 1966, Final Report and Minutes of the Meetings*, 127.

would in turn be key to any eradication efforts and pointed to OCEAC positively as being in a position to coordinate vaccination programs. He concluded that because of OCEAC, Cameroon would be protected completely along its eastern border but that a ‘threat’ still remained on the western border with Nigeria.<sup>546</sup> Dr. Keita of Chad attributed smallpox in his country to ‘imported’ cases and highlighted that the mobile health teams had been doing regular smallpox vaccination for over ten years. He pointed to the need for coverage of vaccination along the borders of Chad, particularly given the passage through his country of people traveling from Nigeria and Francophone West Africa on their pilgrimage to Mecca.<sup>547</sup> Dr. Beday-Ngaro of the Central African Republic characterized his country as a ‘fortunate exception’ among African countries south of the Sahara in regards to smallpox, due to the work of the mobile health teams. The Central African Republic should support the smallpox eradication program, he argued, because of its central position within Africa and length of its borders.<sup>548</sup> Among the OCEAC countries, only Simon Gokana of Congo Brazzaville characterized smallpox within his country as arising from internal factors; he attributed outbreaks of the disease from 1962-1964 to people ceasing attendance at vaccination sessions after independence.<sup>549</sup> Most of these doctors and

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<sup>546</sup> WHO AFR/RC 16/11 Rev. 1, World Health Organization Regional Office for Africa, *Sixteenth Session of the WHO Regional Committee for Africa, Held in Kinshasa, Democratic Republic of the Congo from 12 to 22 September 1966, Final Report and Minutes of the Meetings*, 128. Dr. Adesuyi, representing Nigeria, responded to Happi that the threat of smallpox spreading from Nigeria was ‘not as great as he had anticipated.’

<sup>547</sup> WHO AFR/RC 16/11 Rev. 1, World Health Organization Regional Office for Africa, *Sixteenth Session of the WHO Regional Committee for Africa, Held in Kinshasa, Democratic Republic of the Congo from 12 to 22 September 1966, Final Report and Minutes of the Meetings*, 130.

<sup>548</sup> WHO AFR/RC 16/11 Rev. 1, World Health Organization Regional Office for Africa, *Sixteenth Session of the WHO Regional Committee for Africa, Held in Kinshasa, Democratic Republic of the Congo from 12 to 22 September 1966, Final Report and Minutes of the Meetings*, 127.

<sup>549</sup> WHO AFR/RC 16/11 Rev. 1, World Health Organization Regional Office for Africa, *Sixteenth Session of the WHO Regional Committee for Africa, Held in Kinshasa, Democratic Republic of the Congo from 12 to 22 September 1966, Final Report and Minutes of the Meetings*, 130. Gokana said the number of cases had fallen after 1964 because authorities had convinced people again of the need for vaccination.

health ministers instead characterized their investment in the smallpox program on the basis of addressing a problem that originated beyond their borders, both nationally and regionally conceived.

On June 30, 1966, Dr. Happi and the US Ambassador to Cameroon signed a final grant agreement between OCEAC and the US for the smallpox/measles program.<sup>550</sup> The grant agreement stated that no AID-financed materials could be provided to Congo-Brazzaville until OCEAC, USAID, and the CDC all agreed on a plan of operation for the country.<sup>551</sup> OCEAC countries (excluding Congo-Brazzaville) subsequently signed additional bilateral agreements with the United States in the fall of 1966 and CDC officers began to arrive in-country.<sup>552</sup> Two Americans would be based in Yaoundé: Dr. Arlan Rosenbloom as a Medical Officer and John McEnanay as an Operations Officer. Discussion of the launch of the program continued through 1967, with the official program set to launch in the second half of the year. The

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<sup>550</sup> WHO *Rapport Final de la Troisième Conférence Ministérielle Inter Etats de l'O.C.E.A.C, Libreville le 20 et 21 Juin 1967*, 14. The first grant for the program allocated approximately 185 million CFA, or \$735,000, divided among the five member states of OCEAC and \$10,000 for OCEAC operating expenses. The National Archives at Atlanta, RG 442-CL-06-33-02, Box 3, Folder 21, Cablegram, Department of State from American Embassy Yaoundé, Barrows, to RUEWC/SECSTATE WASHDC Priority YOAID 410. June 30, 1966. To: AID, From: Yaounde, Subject Measles-Smallpox Grant OCEAC, Drafted by Felix J. Lapinski. Successive amendments would bring the total amount of US-AID funding to OCEAC states to \$2,346,000 by 1970. World Health Organization Library, *World Health Organization Regional Committee for Africa, 20<sup>th</sup> Session*, "Surveillance and Co-ordination in the Control of Communicable Diseases in Africa," Report on a meeting convened by the Regional Office for Africa of the World Health Organization, Brazzaville 18-19 March 1970. AFRO 0053 AFR/CD/24, 29 May 1970.

<sup>551</sup> The National Archives at Atlanta, RG 442-CL-06-33-02, Box 3, Folder 21, Airgram, July 12, 1966. To: AID, From: Yaounde, Subject Measles-Smallpox Grant OCEAC, Drafted by Felix J. Lapinski.

<sup>552</sup> Statistics Unit (Author); Smallpox Eradication Program, "West Africa Smallpox Eradication/Measles Control Program Surveillance Report No. 2," The Global Health Chronicles, accessed May 5, 2016, <http://www.globalhealthchronicles.org/items/show/3040>. The agreements for OCEAC countries were signed as follows, Cameroon: October 15, 1966; Gabon: October 24, 1966; Chad: October 25, 1966, CAR: November 15, 1966. CDC officers and arrival dates: Cameroon: Medical Officer Arlan Rosenbloom (also covering Gabon) (arrival date unknown) and Operations Officer John McEnanay, arrived October 31, 1966; CAR: Operations Officer, Neal Ewen, arrived December 8, 1966; Chad: Medical Officer Bernard Lourie (also assigned to CAR), arrived November 10, 1966 and Operations Officer. Russell Charter, November 3, 1966; Gabon: Operations Officer, Mark LaPointe, November 4, 1966.



question of operations in Congo continued to be a point of negotiation. In February 1967, OCEAC signed an amendment to the June 1966 agreement with the US that specified the amounts of vaccine and materials that would be sent to Congo and OCEAC, and noted that OCEAC representatives would act in place of American representatives in the campaign.<sup>553</sup> The campaign ultimately began in 1968 in Congo.<sup>554</sup>

This arrangement solidified the category of “OCEAC countries” within the US-financed regional smallpox program, a categorization reproduced throughout CDC reporting and correspondence, with Yaoundé as its center. This arrangement thus imprinted the public health geography created through OCEAC’s inception onto the first major global health program occurring after independence in the African states. The planning, negotiation and launch of the smallpox program with the coordinating involvement of OCEAC thus brought the assertion of the member states of constituting a health region into the heart of operations of this campaign. It moreover positioned Labusquière as a primary broker of these relationships. Through the smallpox program, Labusquière and Happi both advanced an international politics of health for Cameroon deeply rooted in the ongoing power of France and a regional model for health coordination framed through the geography of French empire.

At the same time, Dr. Happi continued to cast the role of OCEAC as one that gave power to the member states in dealing with international agencies, particularly the Americans, as well as one that furthered public health goals. Dr. Happi pointed to the outcome over Congo-

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<sup>553</sup> WHO, *Rapport Final de la Troisième Conférence Ministérielle Inter-Etats de l’O.C.E.A.C., Libreville le 20 et 21 Juin 1967*, 14.

<sup>554</sup> Centre Pasteur du Cameroun, *Activité des Services des Grandes Endémies des Etats-Membres, Synthèse Globale, Rapport Annuel 1967, O.C.E.A.C.*, 55.

Brazzaville as proving OCEAC's utility. In a 1967 OCEAC meeting, he noted that the Minister of Health of Congo sat 'on the same benches' as the US representatives as "proof that we have succeeded in breaking down certain regrettable barriers."<sup>555</sup> At the inter-ministerial conference of OCEAC in that same year, Happi again raised this example, saying that OCEAC was an organization that had allowed them to "grease the wheels of the machine" by being an intermediary to provide vaccines to Congo, concluding that this proved that "unity is strength."<sup>556</sup> OCEAC continued to paradoxically represent both the continuation of French dominance in aspects of the medical systems of African states as well as a platform for a vision of regional African integration. With the smallpox eradication program, these two factors both gained great significance for the functioning of international public health.

## **West Cameroon**

In the federated state of West Cameroon, like in much of East Cameroon, planning for the smallpox program raised new questions about the politics and logistics of coordinating this influx of international resources and the goal of eradication. A crucial difference between West and East Cameroon, however, came in how health officials saw the potential links between existing medical infrastructure and the eradication program. OCEAC discussions of the planning of the program asserted that existing national mobile health teams, growing out of the infrastructure of French colonial administration, would form the basis of the program at national and regional levels. But this discussion did not highlight the regional exception of Cameroon as

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<sup>555</sup> OCEAC Archives, *Rapport Final de la Deuxième Conférence Technique de L'O.C.E.A.C. Yaoundé du 30 Janvier au 3 Février 1967* Tome I, 10.

<sup>556</sup> World Health Organization Library, *Rapport Final de la Troisième Conférence Ministérielle Inter Etats de l'O.C.E.A.C, Libreville le 20 et 21 Juin 1967*, 87.

a federal republic, with the federated state of West Cameroon that had been under British colonial administration.<sup>557</sup> How did the smallpox program operate in West Cameroon and what does this reveal about the relationships between international, regional and national politics of public health?

As Chapter 3 describes, the initial push in the 1960s to extend the mobile health team model to West Cameroon was part of a broader negotiation between West and East Cameroonians about the fault lines of colonial legacy, medical infrastructure and training between the anglophone and francophone federated states. The smallpox eradication program brought new resources and forms of international connection into this discussion. On one hand, these resources and the imperative of eradication facilitated aspects of the ‘harmonization’ of public health administration across the two states. On the other hand, the program created new professional networks between health officials in West Cameroon and their East Cameroonian counterparts, with French doctors and American officials.

In 1967, Dr. Thomas C. Nchinda, became the Deputy Director of Public Health to the Director of Medical Services for West Cameroon, with the responsibility to oversee the mobile and rural health service, the *Service des Grandes Endémies et de la Médecine Rurale* (SGEMR) for the federated state of West Cameroon.<sup>558</sup> The Federal Ministry of Health in Yaoundé, led by Dr. Happi, gave Dr. Nchinda the task of aligning work in West Cameroon with that of the mobile health team service in East Cameroon. In this role, he thereby became the direct liaison

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<sup>557</sup> The CDC and WHO histories similarly draw a distinction between the existing medical infrastructures in former British and former French colonies in Africa, but gloss over the implications of this for Cameroon.

<sup>558</sup> Email correspondence with Dr. Nchinda, February 13, 2014. See also, National Archives of Cameroon, *Agence Camerounaise de Presse*, No. 301 Jeudi 29 décembre 1966 announcing his appointment to the position by presidential decree on December 24, 1966. See Chapter 3 for further background on Dr. Nchinda. He completed his medical studies at the University of Ibadan, Nigeria and then returned to Cameroon in the early 1960s.

for the Ministry of Health on matters related to the SGEMR in West Cameroon.<sup>559</sup> He also became the liaison for the Assistant Director of the SGEMR at that time, Dr. André Delas, a French military doctor.<sup>560</sup>

It was ultimately through the influx of resources of the smallpox eradication program that Dr. Nchinda was able to pursue the goal of restructuring and revitalizing vaccination work in West Cameroon in standardization with the system in East Cameroon.<sup>561</sup> Dr. Nchinda retrospectively described the organization of the program:

I planned it almost military style going from village to village from Victoria (now Limbe) in the South through to Nkambe in the North with the assistance of the 2 USAID consultants to the project. We ran a one week training session in Limbe prior to the start. My Field Unit workers were brought down to Limbe from all over West Cameroon and trained to use the Ped-o-Jets brought in by the USAID team for use in the vaccinations.<sup>562</sup>

The teams conducting the smallpox and measles vaccinations in West Cameroon largely drew on existing medical personnel, former Medical Field Unit staff and “Yaws Scouts.”<sup>563</sup> In this way, the system of Cameroonian medical staff developed during the British administration of

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<sup>559</sup> Email correspondence with Dr. Nchinda, February 14, 2104. This administrative structure changed in 1972 when the Federal Republic ended and East and West Cameroon merged to form the United Republic of Cameroon.

<sup>560</sup> NAC Buea. Sc/a/1968/15. Correspondence between Delas and Nchinda about measles cases and vaccination.

<sup>561</sup> The smallpox and measles vaccination campaign launched in West Cameroon from April to September of 1967. OCEAC Archives, “Les Campagnes de Vaccination Associées Au Cameroun, » Par le Docteur André E. Delas, *Rapport Final de la Troisième Conférence Technique de l’O.C.E.A.C., Yaoundé du 24 au 27 Janvier 1968*, Tome II, 518. The campaign included the smallpox vaccine for 56.1% of the total population of West Cameroon and the measles vaccine for 57% of the population of children aged 6 months to 6 years in West Cameroon.; Centre Pasteur du Cameroun, *Activité des Services des Grandes Endemies des Etats-Membres, Synthese Globale, Rapport Annuel 1967, O.C.E.A.C*, 68. In total, 575,802 smallpox vaccines were given in West Cameroon in 1967.

<sup>562</sup> Email correspondence with Dr. Nchinda, February 13, 2014.

<sup>563</sup> Email correspondence with Dr. Nchinda, February 14, 2014. Correspondence February 13, 2014 “In West Cameroon prior to Independence, control of Communicable diseases was handled by Medical Field Unit Teams and they handled, among other diseases, the Smallpox Vaccinations nationwide. This team had in its ranks Yaws Scouts who searched for Yaws cases and these were treated with Penicilline by the Field Unit Teams.

West Cameroon became restructured to align with a mobile health team model forged through French colonialism, all in service of a major global health initiative funded here by the United States. Moreover, a West Cameroonian doctor trained in Nigeria coordinated this program on the ground. Few other arrangements show so clearly how the smallpox program in Cameroon intersected with the politics of public health in Cameroon, with its dual colonial legacy and status as a federal republic with ongoing ties to France. The reorganization of mobile health work in West Cameroon was forged through the smallpox campaign, but this outcome was a product of both the effort from Yaoundé to harmonize public health administration across the federated states as it was the global eradication effort. In other words, the global goal provided the impetus and resources to more aggressively pursue national reforms.

The smallpox program created the necessity of re-organizing vaccination teams in West Cameroon, but it also provided the resources to do so. Local health officials in Mamfe in West Cameroon reported that before the start of the smallpox/measles campaign in April 1967, “the activities of the M.F.U. [Medical Field Units] have been more or less at a standstill owing to lack of funds, transport and the necessary drugs.”<sup>564</sup> In 1968, the mobile team in Mamfe reported doing most of its work with the Dodge lorry provided by the US through the smallpox program, facilitating the administration of over 27,000 vaccinations.<sup>565</sup> Officials in the Wum

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<sup>564</sup> NAC Buea. Sc/a 1966/13, Medical Annual Report 1967. General Hospital, Mamfe. January 24, 1968. Notably this section of the report listed activities under the heading: Medical Field Unit (Grandes Endémies), combining the names of the original services from East and West Cameroon.

<sup>565</sup> NAC Buea. Sc/a 1966/13, Annual Medical Report, Mamfe Mobile Team Activities and Rural Health Services-Annual Report of 1<sup>st</sup> January-30<sup>th</sup> June, 1968. Health Office, Mamfe, West Cameroon, 26<sup>th</sup> July 1968. By contrast, Mamfe officials reported that the specialized Leprosy service was doing most of their work on foot and as a result had been ‘considerably curtailed.’ The report called for the need for additional transport in the division.

medical division reported a similar state of affairs.<sup>566</sup> Dr. Delas marked 1967 as the turning point when the mobile service was seriously reorganized in West Cameroon.<sup>567</sup> Delas noted, in fact, that health officials in Cameroon had directed a significant portion of the overall material coming in through the smallpox program had been put towards the campaign in West Cameroon, such that operations in the rest of the country were constricted.<sup>568</sup>

As the smallpox program continued, Dr. Nchinda also saw an opportunity to try and address an ongoing issue of the flow of health resources from the capital in Yaoundé to the state of West Cameroon. In an interview I conducted with him in 2014, Dr. Nchinda recalled that getting some of the supplies and equipment in Yaoundé to “trickle down” to West Cameroon was one of his “biggest headaches and challenges.” He “generally bargained very hard for anything” and had to prove himself in the Ministry of Health, “where there was always a lot of skepticism about things emanating from West Cameroon.” He recalled setting out on the task of reorganizing the mobile health teams with “very limited means.”<sup>569</sup> As teams in West Cameroon continued to pursue smallpox and measles vaccination, Dr. Nchinda made a request to Dr. Rosenbloom from the CDC to assign an additional Operations Officer specifically for West Cameroon, in addition to John McEnaney in Yaoundé.<sup>570</sup> He recalled this as a strategic

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<sup>566</sup> NAC Buea. Sc/a 1966/13, Annual Report 1967, General Hospital, Wum. January 18, 1968. Officials in Wum reported that the Grandes Endemies team had mostly worked in the general hospital due to the shortage of funds, but mass measles and smallpox vaccinations were carried out across the division.

<sup>567</sup> WHO, *Rapport Final de la Quatrième Conférence Technique de l'O.C.E.A.C. Yaoundé du 21 au 25 Janvier 1969, Tome I*, 140.

<sup>568</sup> WHO, *Rapport Final de la Troisième Conférence Ministérielle Inter-Etats de L'O.C.E.A.C. Libreville le 20 et 21 Juin 1967*, 25.

<sup>569</sup> Email correspondence with Dr. Nchinda, February 19, 2014. Interview with Dr. Nchinda, May 22, 2014. Founex, Switzerland.

<sup>570</sup> National Archives of Cameroon, Buea. Sc/a/1968/15, Letter from Arlan L. Rosenbloom, M.D. to Dr. T.C. Nchinda, Deputy Director of Health, Medical Headquarters, Victoria, West Cameroun. February 27, 1968.

move, hoping that having an Operations Officer on site would allow for a greater visibility of the needs of the area and a more direct response to them.<sup>571</sup> USAID/CDC did not ultimately fulfill the request for an Operations Officer, but Dr. Nchinda remembers things improving after taking Drs. Delas and Rosenbloom on a tour of rural health centers in West Cameroon.<sup>572</sup> Dr. Delas subsequently sent a new vehicle for Dr. Nchinda's professional use.<sup>573</sup> The eradication program thus opened new avenues through which Cameroonian health officials worked to reorient health resources within the country.

Dr. Nchinda's role as both a high-ranking English-speaking health official in Cameroon and medical official for the smallpox eradication program meanwhile opened new opportunities for him to participate in international health training and networks. In the summer of 1968, he traveled to Atlanta as the sole representative from Cameroon to participate in a training course on epidemiology at the CDC.<sup>574</sup> He attended OCEAC technical conferences in Yaoundé to represent the program in West Cameroon and also attended meetings of the World Health Organization's World Health Assembly as part of the Cameroonian delegation between 1966 and 1972.<sup>575</sup> While Drs. Labusquière and Happi asserted the francophone grouping of OCEAC as a framework for the smallpox eradication program from Yaoundé, Dr. Nchinda's work simultaneously created other avenues of international medical connection—with East

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<sup>571</sup> Email correspondence with Dr. Nchinda, February 19, 2014. Interview with Dr. Nchinda, May 22, 2014. Founex, Switzerland.

<sup>572</sup> Email correspondence with Dr. Nchinda, February 14 & 19, 2014.

<sup>573</sup> Email correspondence with Dr. Nchinda, February 14 & 19, 2014.

<sup>574</sup> Interview with Dr. Nchinda, May 22, 2014. Photograph of training participants published in: Horace G. Ogden, *CDC and the Smallpox Crusade* (Atlanta, GA : U.S. Department of Health and Human Services, Public Health Services, Centers for Disease Control, 1987).

<sup>575</sup> Email correspondence with Dr. Nchinda, February 10, 2014.

Cameroonian, French and American doctors—that were a unique product of the eradication program. These connections began Dr. Nchinda’s travel in international health circuits, which later culminated in his career at the World Health Organization in Geneva from 1983 through his retirement.

Moreover, while health officials at OCEAC focused on medical cooperation with francophone states, questions arose in West Cameroon about other international orientations and cross-border politics, particularly about how the movement of people across the border with Nigeria would impact the spread of disease and the need for vaccination. These concerns came amidst great upheaval caused by the Nigerian Civil War, with West Cameroon sharing a full border with the self-declared independent state of Biafra.<sup>576</sup> Reports of measles cases in the West Cameroonian town of Victoria (present day Limbe) in March 1968 traced back to mostly unvaccinated individuals in a village outside of Victoria, ‘made up mainly Nigerians (particularly Biafrans).’ As a result, two West Cameroonian medical personnel dispatched to the village to administer both smallpox and measles vaccinations.<sup>577</sup> In June 1969, Dr. Nchinda responded to federal government officials with assurances about steps being taken to vaccinate

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<sup>576</sup> NAC Buea. Sc/a/1966/13. Undated medical report: “Routine vaccination was undertaken by the health staff, more especially at the time when disturbances in Eastern Nigeria caused an influx of refugees to enter West Cameroon. The new entrants were screened and supervised as much as possible and wherever necessary vaccination was carried out. A systematic form of vaccination extending to all over West Cameroon will be done in 1967.” Email correspondence with Dr. Nchinda, 2/19/14. “There was much influx of people from Eastern Nigeria to Cameroon during the Biafran war. There were already many Ibos and Efiks living in West Cameroon especially Kumba, Victoria and Tiko from the colonial period since Cameroon was administered as part of Nigeria... Those Ibos who escaped to West Cameroon during the Biafran war generally moved in with their families who had been living in Cameroon over the years. Many of these migrants found it worth their while to participate in these vaccination efforts.” Interview with Dr. Nchinda: He also recalled this cross-border movement as in many ways being not visible because people went from Biafra to live with family in Cameroon. National identity cards were not required for vaccination. For a discussion of the smallpox program in Biafra: Fenner, F. et al. *Smallpox and its Eradication* (Geneva: World Health Organization), 1988, 882-883.

<sup>577</sup> NAC Buea Sc/a/1968/15. March 8, 1968. Dr. T.C. Nchinda, Deputy Director of Health to Monsieur le Sous Directeur des Grandes Endemies et de la Medecine Rural Commissariat General à la Santé Publique, Yaoundé. ; sc/a/1966/13, Dr. G. F. Epanty, Medical Officer, General Hospital, Medical Department, Victoria, West Cameroon, Annual Report 1<sup>st</sup> January 1968-30<sup>th</sup> June 1968.



all Nigerians or other people crossing into Cameroon, and pointed to work by mobile health teams in the past year at key locations.

The mobility of people across this border highlighted both the harsh conditions of the civil war occurring in Nigeria as well as the historical and contemporary ties between Eastern Nigeria and West Cameroon. In West Cameroon, the OCEAC framing of francophone health cooperation through shared health problems and solutions appeared removed from the realities of both the movements of people and the history of health infrastructure. The organization's insistence on cooperation with its francophone neighbors obscured the historical ties of Cameroonian communities across the Nigerian border. In contrast to the politics of the planning for the program in Yaoundé, in West Cameroon (Buea), the program planning reflected the very particular history of the state's complicated former ties to Nigeria, the legacy of British colonial medical administration, and its position as a federated state of the Republic of Cameroon.

### **Northern Cameroon and Eradication**

The final push of the smallpox eradication program in Cameroon ultimately focused on mobility across the Nigerian border. On one hand, French military doctors with the mobile health service shaped responses to the work in this region through their leadership of vaccination teams, investigation of cases, and broader shaping of the understanding of smallpox in the area. On the other hand, this final stretch of the campaign highlighted the limitations of the OCEAC conception of the health region as a framework for disease eradication. Oriented towards other francophone states sharing the history of French mobile health teams, this framework did not respond to the ongoing spread of smallpox across the Nigerian/Cameroonian border. It was the absolutist goal of disease eradication that mobilized a new focus on eradicating smallpox in this area.

In 1967, with the smallpox eradication program underway in Cameroon, the only identified cases of smallpox across OCEAC states were identified in northern Cameroon near the Nigerian border and in Chad.<sup>578</sup> Most of the cases in Cameroon, in Fort-Foureaux and in Mokolo, for example, were attributed to importation of the disease from Nigeria.<sup>579</sup> Health officials similarly tracked cases in Chad to people traveling from Nigeria, some in transit to Mecca.<sup>580</sup> OCEAC officials at the time surmised that there were more cases in Cameroon, but that the population notified health officials of cases only very late or when the situation had become very serious.<sup>581</sup>

The problem of smallpox in northern Cameroon in the final stretch of the eradication program reflected a longer history of the disease in the area, and French military doctors who had worked in the north became key intermediaries of the global program. Dr. André Delas, who had overseen the mobile health service in the far north of Cameroon during the 1961 epidemic, was serving in a national position as the Assistant Director of the Cameroonian mobile health service by the late 1960s. His particular experience of smallpox vaccination in northern Cameroon would thus help to shape how the problem of the disease and the problematizing of human movement took shape within the context of the global program.

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<sup>578</sup> Centre Pasteur du Cameroun archives, *Activité des Services des Grandes Endémies des Etats-Membres, Synthèse Globale, Rapport Annuel 1967, O.C.E.A.C.*, 55.

<sup>579</sup> Centre Pasteur du Cameroun archives, *Activité des Services des Grandes Endémies des Etats-Membres, Synthèse Globale, Rapport Annuel 1967, O.C.E.A.C.*, 101.

<sup>580</sup> Centre Pasteur du Cameroun, *Activité des Services des Grandes Endémies des Etats-Membres, Synthèse Globale, Rapport Annuel 1967, O.C.E.A.C.*, 101-102. The OCEAC report discussed the response to the cases in Chad as sufficient, but characterized the area as ‘vulnerable’ due to the mobility and permanent contact of the population with Nigeria.

<sup>581</sup> Centre Pasteur du Cameroun, *Activité des Services des Grandes Endémies des Etats-Membres, Synthèse Globale, Rapport Annuel 1967, O.C.E.A.C.*, 101.

When Delas presented a report in 1969 to a seminar in Lagos on the US-funded smallpox program, he highlighted the porousness of the Cameroon/Nigerian border and its consequences:

Control of the frontier between Cameroon and Nigeria is absolutely impossible. Numerous mountain tracks are used in both directions, and villages and markets exist on the frontier itself. Surveillance of cases and an increase in the vaccination coverage in the two countries concerned are the only measures possible to achieve control of the disease.<sup>582</sup>

Delas's position more broadly illustrated how French doctors of the mobile health service positioned themselves as brokers of the smallpox program, as 'local' experts vis a vis international health through the program.

At the same time, the goal of eradication elevated the situation in northern Cameroon to one of global concern and catalyzed intensified attention. This goal brought new attention to cross-border mobility as well as to people's response to vaccination. This resistance to vaccination—emerging out of a history of biomedical intervention under colonial rule and its locally negligible reformulation after independence—thus now became something to be combatted with new resources, and with new foreigners. Two Cameroonian mobile teams responded to the 1967 outbreak, administering 60,000 vaccinations with an additional surveillance team performing control work.<sup>583</sup> The mobile health team service in Mokolo reported during this time that the population there feared vaccination more than smallpox

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<sup>582</sup> André Delas, "Investigation of Imported Cases During the Smallpox Eradication Programme in Cameroon," Proceedings jointly sponsored by the World Health Organization, the U.S. Agency for International Development, and the National Communicable Disease Center, Seminar on Smallpox Eradication and Measles Control in Western and Central Africa (1969: Lagos, Nigeria). (1970) Author: United States National Communicable Disease Center, 183.

<sup>583</sup> *Rapport Final de la Troisième Conférence Technique de l'OCEAC, Yaoundé du 24 au 27 Janvier 1968, Tome I*, 20.

itself.<sup>584</sup> Dr. Arlan Rosenbloom and John P. McEnaney, the CDC officers based in Cameroon, worked with the mobile team service in Mokolo and focused on using market days to extend vaccination coverage.<sup>585</sup> OCEAC officials attributed the successful response to the outbreak to all of the resources made available and to the direct assistance of the Americans, which permitted the vaccination of ‘a large part of the population of this mountainous region, particularly resistant to vaccination.’<sup>586</sup> The eradication program thus increased the stakes of this resistance, and the attention it merited, to one of global consequence.<sup>587</sup>

The eradication program would likewise make the mobility and the routes traveled by people across northern Cameroon and northern Nigeria a matter of global health concern. One of the outbreaks of smallpox in 1967 gives a particularly vivid example of the cross-border mobility at the heart of both the spread of smallpox and the response. On November 18, 1967, the French SGE physician based at Fort Foreau Cameroon, Dr. Genevois, heard about a potential outbreak of smallpox in the village of N’Game from the *chef de Canton* of the town of Afade. A Cameroonian nurse traveled to N’Game and identified four cases of smallpox and on November 21<sup>st</sup> a mobile team subsequently vaccinated roughly four thousand people in and around the village. After Dr. Genevois identified a new case of smallpox in the village that day,

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<sup>584</sup> Centre Pasteur du Cameroun, *Activité des Services des Grandes Endémies des Etats-Membres, Synthèse Globale, Rapport Annuel 1967, O.C.E.A.C*, 59.

<sup>585</sup> Ogden, 62.

<sup>586</sup> Centre Pasteur du Cameroun, *Activité des Services des Grandes Endémies des Etats-Membres, Synthèse Globale, Rapport Annuel 1967, O.C.E.A.C*, 101. The CDC account of the smallpox campaign attributes success in vaccinating people during this outbreak to Rosenbloom and McEnaney’s tying of the vaccination schedule to local market days. Ogden, 63.

<sup>587</sup> For a discussion of a contemporary example of local resistance to vaccination in the context of a disease eradication program, see: Elisha P. Renne, *The Politics of Polio in Northern Nigeria* (Bloomington: Indiana University Press, 2010).

he reported the cases, in light of the geographic proximity, to the Director of the SGE in Chad, Dr. Pierre Zeigler. Dr. Bernard Lourie, the CDC officer based in Chad, travelled into Cameroon with Dr. Zeigler to investigate the cases.<sup>588</sup> The CDC history of the smallpox program mentions this outbreak and characterizes the travel of Dr. Lourie and Dr. Zeigler into Cameroon as ‘an excellent example of the intercountry cooperation made possible by the regional program.’ I would argue that this particular cooperation and mobility, prompted by the communication between French physicians, was rooted in the history of the French colonial medical service and the framework of cooperation through OCEAC, more so than through the CDC conception of a regional program for West and Central Africa.

They ultimately traced the outbreak back to a one year old girl. The CDC reports detailed:

In late August or early September the vaccinated mother of case No. 1 went to Nigeria to visit some relatives, taking her non-vaccinated baby girl with her. She took a public bus to the border town of Fotocol, and then walked some ten kilometers to the town of Gamerou where her relatives lived. She stayed five days in Gamerou. During this time she always kept her baby with her. She denies that there was anybody sick in Gamerou at that time. She denies that anyone had any skin lesions. After five days, she started back home, walking again to Fotocol and again taking the bus. At N’blame the rain barriers were down and the bus could go no further. She therefore walked about 25 kilometers (with the baby) until she reached her home in N’Game. She made the entire trip from Gamerou to N’Came in less than one day. She had needed no documents to cross the frontier. Ten days after she got home, the baby developed a fever and a popular rash. She states that on the third day of the rash she took the baby to the dispensary at AFADE for treatment (this point is being checked with the dispensary records). In any case the diagnosis of smallpox was not made. All of the subsequent cases lived in the same compound.<sup>589</sup>

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<sup>588</sup> WHO Smallpox Country Files, Cameroon, “Extrait Rapport sur 5 cas de Variole constatés dans le Logone et Chari. »; Ogden, 63.

<sup>589</sup> WHO Smallpox Country Files, Cameroon, “Extrait Rapport sur 5 cas de Variole constatés dans le Logone et Chari. » The other people in the compound who developed cases of smallpox were unvaccinated children, aged 15

In March of 1967, CDC officials similarly tracked an outbreak of measles to the travel of a Nigerian woman from Mokoua with her infant. They traveled from Mokoua through various Nigerian towns and eventually to Fort Foreau, Cameroon, stopping there for ten days and then crossing over into Chad by ferry. They noted that she did not need to show any vaccination certificate to make any of these crossings.<sup>590</sup>

These cases of women traveling across a border and producing no documentation in the process demonstrated a fluidity of movement at odds with the idea of a rigidly constructed political or meaningful medical border. Categorizing ‘imported’ smallpox cases in this location within the context of a global eradication campaign was rather a tool to assign responsibility—designating who should respond to a particular outbreak within a national context, but also designating that the source of that outbreak lay elsewhere. On one hand, this categorization upheld the importance of the national border as a medical border signifying accountability. On the other hand, it highlighted the ultimate irrelevance of these distinctions in the context of the broader goal of eradication. Smallpox eradication would only be complete once it was truly global, but within that pursuit, health officials continued to work through smaller geographic units and to frame problems and approaches through these units.

Health officials based in Mokolo in northern Cameroon recognized this fluidity and called for joint campaigns across the Nigerian/Cameroonian border, observing that people

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and under. The fifteen year old girl in the household who contracted smallpox was noted as having helped care for the infant who had the original case.

<sup>590</sup> George Lythcott; CDC; Regional SEP Director, “Regional Office May Report,” *The Global Health Chronicles*, accessed May 24, 2016, <http://www.globalhealthchronicles.org/items/show/3018>.

wishing to escape vaccination could easily do so by crossing over the border.<sup>591</sup> As more cases of smallpox cropped up in 1968 in northern Cameroon in the administrative departments of Margui-Wandala, Mayo Danaye, and Bénoué, Dr. Delas argued that the danger of smallpox in Cameroon would persist until immunization coverage was realized in northern Nigeria.<sup>592</sup> And at his request, American officials began sharing weekly reports on smallpox cases in Nigeria. He echoed local officials in northern Cameroon, saying that what was really necessary was to know when vaccination was happening across the border in order to coordinate.<sup>593</sup>

If the movement of people across these geographic spaces, and thus the consequences for the spread of disease, was old, the level of concern by health officials about the outcome of this mobility was new in its urgency and was oriented towards the absolutist goal of smallpox eradication. A globally oriented approach to disease still had to work through national health infrastructures and thereby at local levels, such as that of Mokolo, attention to the importance of national borders and their permeability in fact became more pronounced from a public health perspective. Health officials within Cameroon faced new urgency in the face of the eradication program to address cases of smallpox within its borders, even as the epidemiology of the disease grew from cross-border movement, in a location where the history and significance of that border as marking a political delineation was shifting and unstable.<sup>594</sup>

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<sup>591</sup> SHD. *Rapport Final de la Quatrième Conférence Ministérielle Inter-Etats de l'OCEAC*, Bangui le 28 et 29 Octobre 1968, 80.

<sup>592</sup> WHO *Rapport Final de la Quatrième Conférence Technique de l'OCEAC Yaoundé du 21 au 25 Janvier, 1969*, 21.

<sup>593</sup> WHO, *Rapport Final de la Quatrième Conférence Technique de l'OCEAC Yaoundé du 21 au 25 Janvier, 1969*, 358.

<sup>594</sup> On the 'frontier zone' of northern Cameroon and Nigeria, see Janet Roitman, *Fiscal Disobedience: An Anthropology of Economic Regulation in Central Africa* (Princeton, NJ: Princeton University Press, 2005), 101-103.

Notably, smallpox persisted across a transnational geographic space at odds with OCEAC's proposed health region. French and Central African health officials argued that this region grew naturally from the shared history of French colonial mobile health teams, a vision of continuing this system after independence, and of shared health problems. OCEAC's reliance on the trope of disease knowing no borders and insistence that its organization responded to this fundamental truth, did not, in fact, correspond to the movement of people across the Cameroonian/Nigerian border, movement rooted in a different, deeper, social and political history of the region. Thus, while OCEAC, through a refashioned colonial medical infrastructure, became the basis for the operations of the smallpox campaign, it was the lived movement of Cameroonians outside of and across this space that set the final parameters of smallpox eradication in Cameroon.

## Conclusion

In 1969, the last ever recorded cases of smallpox within the five member states of OCEAC were reported in Cameroon.<sup>595</sup> The US-funded regional program in West and Central Africa meanwhile produced wider success quickly. The program began across most countries in 1967 and the last case of smallpox in the region was detected in 1970.<sup>596</sup> This regional success bolstered the global eradication program, which proceeded under the umbrella of the WHO through the 1970s until the official pronouncement in 1980 that smallpox had been completely eradicated from the world.<sup>597</sup> The US-funded vaccination program continued

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<sup>595</sup> Horace G. Ogden, *CDC and the Smallpox Crusade* (Atlanta, GA : U.S. Department of Health and Human Services, Public Health Services, Centers for Disease Control, 1987), 62.

<sup>596</sup> Frank Fenner et al. *Smallpox and its Eradication* (Geneva: World Health Organization), 1988, 849.

<sup>597</sup> Stepan, 8.



formally through 1972, and at the end of this time, the second arm of the program had not achieved success; measles outbreaks continued to beset Cameroon and neighboring countries.<sup>598</sup>

The eradication program in Cameroon played a small part in the vast effort at global eradication, but the program began at a critical juncture for Cameroonian and French health officials in negotiating their internal and external working relationships and the formulation of national and regional health policy. Through these negotiations, Central African health officials and doctors and the French doctors still working in these countries made mobile health teams, both in their on the ground local work and their regional conception through OCEAC, into the basis for the first major global health campaign after independence. At the same time, the eradication program highlighted the margins of this medical framework within Cameroon—of the need to extend the model in West Cameroon and of its limitations, both past and present, in Northern Cameroon.

The program likewise forged new international medical connections, at both individual and institutional levels. Drs. Happi and Nchinda of Cameroon each took on new roles in the negotiations of international health programs through national and regional structures. Drs. Labusquière and Delas meanwhile carved out new post-independence roles as French intermediaries of international health programs in Africa. Connections between these health officials and Americans would continue in new institutionalized ways: the CDC placed senior epidemiologists at both OCEAC in Yaoundé and the West African *Organization de Coordination et de Coopération pour la Lutte contre les Grandes Endémies* (OCCGE) after the termination of the program as a way to maintain involvement in the health work of the member

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<sup>598</sup> Bernard Guyer and A Marshall McBean, “The Epidemiology and Control of Measles in Yaoundé, Cameroun, 1968-1975,” *International Journal of Epidemiology* 10 (1981): 263.

countries.<sup>599</sup> In the early 1970s, USAID provided funding for new small-scale programs in Maternal and Child health coordinated through OCEAC and for the building of a training center at OCEAC headquarters.<sup>600</sup> Through these connections, Yaoundé's identity as a central site for international health work within Central Africa became greatly strengthened through the smallpox program.

The smallpox program was also, in many ways, a culmination of the work of the mobile health teams, as they had previously existed, in independent Cameroon. During the program's operations, Cameroonian health officials were simultaneously engaged in work in coordination with the World Health Organization to alter the structure and role of the teams within the country's overall public health system.<sup>601</sup> Moreover, the conclusion of the smallpox program within Western and Central Africa prompted health officials-both from within and outside of Africa- to call for the creation of an 'Inter-Country Coordination Committee on Communicable Diseases for West and Central Africa,' citing the 'vacuum' of coordination that could occur with the end of the smallpox program. Dr. Happi and other OCEAC health ministers advanced this recommendation for discussion in the WHO Africa office, a recommendation that in many ways recognized some of the limitations of their own organization as a coordinating body on health.<sup>602</sup> The period of the smallpox eradication program in Cameroon thus encapsulated a very particular moment in the country's establishment of its public health policies, at once

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<sup>599</sup> Ogden, 74.

<sup>600</sup> The National Archives at College Park, Maryland. 286-150-76-4-1-4, Box 7. August 11, 1970. Memorandum, To: Julius S. Prince, MD. AFR/TAC, From: Ernest E. Neal, RPA, Accra, Subject: OCEAC and CUSS Projects, Yaoundé. AID personnel expressed some confusion about what the role of OCEAC versus the individual member states' Health Ministries would be in these projects.

<sup>601</sup> See Chapter 5.

<sup>602</sup> WHO, *World Health Organization Regional Committee on Africa, 19<sup>th</sup> Session, 1969*, AFR RC19/3, Annex 1, Annex 2.

marking a further consolidation of national health policy, a reformulation of medical coordination with France and with African neighbors, and the shaping of international health resources through these frameworks.

## Chapter 5: From Mobile Health Teams to Basic Health Services

The Smallpox Eradication Program represented the height of, and by far the greatest success, of the convergence between the mobile health team service in Cameroon and postwar global disease eradication programs. It was thus *after* independence that the successful convergence of the colonial mobile health team model as an implementer of global disease eradication programs seemed most clear. The smallpox campaign took place, however, at the same time as broader shifts in the focus of the World Health Organization and its relationship to the work of Cameroon's Ministry of Health.

As the failures of the global Malaria Eradication Program in many countries became clear, the WHO began to turn its attention over the course of the 1960s to the need of countries to invest in basic health services.<sup>603</sup> Although the most decisive changes to the WHO's focus on primary health care did not occur until the 1970s, this shift had roots in the late 1960s, when the WHO substantially increased the number of projects around the world focused on basic health services. In 1965, the WHO supported 85 such projects worldwide and by 1971, this number nearly doubled to 156.<sup>604</sup> These projects focused on developing permanent health systems that could reach whole populations.

Over the course of the 1960s, the Cameroonian Ministry of Health embraced WHO recommendations and began to develop reforms to the national health administration. The reforms marked a turn away from the campaign-style approach to health intervention in rural areas developed by the mobile health service through the colonial period and into the 1960s

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<sup>603</sup> Packard (2016), 231.

<sup>604</sup> Marcos Cueto, "The Origins of Primary Health Care and Selective Primary Health Care," *American Journal of Public Health* Vol. 94, No. 11 (2004): 1865.

through the organization of the *Service des Grandes Endémies* (SGE). The program pursued by the Cameroonian government, upon advice of the WHO, to reorient rural health care around newly formed rural health centers and diminish the role of mobile teams represented a new vision for public health in the country. As a result, a conflict developed between the French military doctors of the SGE, WHO representatives, and Cameroonian health officials over the future of the mobile health team service and of rural health services more generally.

Cameroonian health officials took steps to reform the national health system in line with WHO recommendations in a manner that French military doctors considered to be too rapid and also a direct attack on the mobile health team model. Through this program, Cameroonian health officials in turn began to carve out a new relationship to the WHO, less heavily marked by the intermediary of the French military doctors of the SGE. I assert in this chapter that, catalyzed by the WHO, these debates over rural health in Cameroon thus in large part centered on the place of the colonial model of the mobile health teams and French *Service des Grandes Endémies* (SGE) doctors in the independent state.

These debates in Cameroon reflected the larger issue of both France and the WHO working to assert influence over health in independent African countries, with each developing different visions of rural health reform in the 1960s. Because the WHO offered primarily technical assistance, and not long-term operational financial support, in this realm, some French officials saw the WHO as spurring reform in African countries that its government would in

turn have to help finance.<sup>605</sup> In 1965, the French Ministry of Cooperation thus put forth its own recommendations for the reorganization of rural health in African countries.<sup>606</sup>

While recognizing this broader debate, my focus in this chapter is on how the ongoing negotiation by Cameroonian officials of the convergence of colonial and international models of health intervention continued to shape national health administration through the late 1960s and into the early 1970s. Debates about this new path for the Cameroonian health administration happened both through national meetings for planning focused on rural medicine as well as at OCEAC meetings. The conflicts in these meetings became explicit, as OCEAC Secretary General Rene Labusquière clashed with WHO representatives. Cameroonian officials, particularly Commissioner General of Health Jean-Claude Happi, sought to reconcile these positions while also moving forward with the plan for the creation of a new rural health system in Cameroon. Although Happi had asserted the primacy of the French mobile health team model through the inauguration of OCEAC and through the smallpox eradication campaign, he also paradoxically became a vocal advocate of a departure from this model through closer collaboration with the WHO. I argue that by simultaneously affirming the maintenance of French systems and their reform through the WHO, Happi and other Cameroonian officials sought to maximize international assistance for the Cameroonian health system while also responding to new political imperatives within the country. These officials asserted that the health situation, in terms of both disease burden and needs of the population was changing, and

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<sup>605</sup> Division of Medical Sciences, National Academy of Sciences National Research Council, *Public Health Problems in 14 French Speaking Countries in Africa and Madagascar: A Survey of Resources and Needs, Volume I*, 1966, 50-51.

<sup>606</sup> Division of Medical Sciences, National Academy of Sciences National Research Council, *Public Health Problems in 14 French Speaking Countries in Africa and Madagascar: A Survey of Resources and Needs, Volume I*, 1966, 51.

they made a case for leveraging multiple avenues of technical assistance to address these changing circumstances. Cameroonian officials did not, however, frame these changes in terms of an overt break with the colonial past. They both adopted a discourse that celebrated the French colonial legacy of medicine and pushed for adaptation of this model to new international norms represented by the WHO.

This stance by Cameroonian health officials in turn forced a new position for the French military doctors involved with running the *Service des Grandes Endémies*, who explicitly took issue with these reforms but ultimately had to work within them in the context of an independent Cameroonian government. OCEAC presented a distinct forum in that it created a space for French doctors to assert authority outside of a purely national context, while still claiming to speak in the interest of independent countries. As the technical leader of OCEAC, Labusquière used his platform to vigorously debate these reforms with the WHO. Labusquière and other French doctors moreover continued to assert their authority, relative to the WHO, of knowledge of local conditions of Cameroon and realities on the ground. The decision by Cameroonian officials to work more closely with the WHO, however, diminished the weight of these claims to singular authority.

Following primarily legislative reform in the mid-1960s, the Cameroonian government began in the late 1960s to develop new models for rural health intervention at the level of pilot projects. The reforms thus remained geographically limited in the 1960s, but their pursuit by the Cameroonian government marked new arrangements of international health. Notably, the government also pursued a new plan for medical training in the country in line with WHO recommendations and away from French models of medical education. It was thus ultimately not the moment of political independence, but rather the response of Cameroonian health

officials to shifting international health priorities, that catalyzed experimentation with moving away from the French mobile health team model. Cameroonian officials sought to maintain strong ties to France but also to optimize other avenues of international health resources, even when those avenues challenged the seeming French-Cameroonian consensus about the value of the mobile health teams.

### **Independence and Pre-Eradication**

The reforms to rural health that the WHO advised and the Cameroonian government adopted grew out of perspectives from the failures of malaria eradication efforts in Cameroon, more broadly in Africa, and across the world. As discussed in Chapter 1, the originally hopeful results of interrupting malaria transmission in southern Cameroon by the end of the 1950s were followed by a powerful resurgence of the disease. Other sites in Africa showed a similar resurgence of malaria transmission following the cessation of the pilot projects.<sup>607</sup> In light of these failures both in and beyond Cameroon, and just as Cameroon gained political independence, the WHO began developing new frameworks for addressing malaria.

As the WHO began to propose new malaria strategies, the independent Cameroonian government in turn faced new decisions about how to coordinate multiple sources of funding and influence in relation to health and medicine. As shown in the previous chapters, France's broader heavy-handed ongoing involvement in Cameroon both extended to, and took on particular form, in the area of medicine and international health. In the early 1960s, Cameroonian health officials closely guarded and solidified the place of the SGE in the national

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<sup>607</sup> James L.A. Webb, Jr. *The Long Struggle against Malaria in Tropical Africa* (New York: Cambridge University Press, 2014), 90.



administration and, in turn, its role in international health. The creation of OCEAC in 1963 and the role of the organization in the Smallpox Eradication Program exemplified these connections.

Early changes to WHO policy on malaria in the 1960s and the embrace by the Cameroonian government of these changes show, however, how the new circumstances of dealing directly with the WHO as an independent nation opened complexities that would grow over the course of the decade. In the case of malaria, Cameroonian health officials developed agreements with both the WHO and with the French *Fonds d'Aide et de Coopération* (FAC) to garner as much technical assistance and funding as possible. They developed these agreements with the WHO at times without coordination with FAC, and thus began to exert a distinct working relationship to the WHO. With Dr. Simon-Pierre Tchoungui, a proud product of the French medical system and early driver of OCEAC's creation, at the helm of the Cameroonian Ministry of Health in the early 1960s, this was not a move to exert independence from French influence as much as it was to capitalize on sources of external assistance in bureaucratically expeditious ways. The embrace of WHO recommendations by Tchoungui, however, opened up a significant avenue of influence on the formation of the national health administration in Cameroon, which would later grow into direct conflict between these recommendations and the French doctors of the SGE.

Following the failures of the malaria pilot zone in southern Cameroon, French, WHO and Cameroonian health officials entered into a period of uncertainty over how to move forward on malaria efforts. In 1961, the Cameroonian government created a National Malaria Eradication Service (*Service National d'Éradication du Paludisme*), as a health service distinct

from the SGE.<sup>608</sup> Although a French military doctor briefly led the new service, by October 1961 it was led by Cameroonian Dr. Samuel Abane Mbomo.<sup>609</sup> In December 1961, French representatives of the *Fonds d'Aide et de Coopération* informed Minister of Health Dr. Simon-Pierre Tchoungui that France would no longer support the malaria program in Cameroon as it existed, given the distant and unpredictable results. FAC would support the functioning of the newly created National Malaria Eradication Service in the short term until the creation of new accords between the Cameroonian government and FAC planned for 1963. FAC meanwhile funded the work of a malaria specialist, *Médecin Général* Bernard, to work in the country and help formulate a new malaria strategy.<sup>610</sup>

At the same time, the WHO began to develop new recommendations for malaria work in African countries, which officials presented during the Third African Malaria Conference, held in July 1962 in Cameroon's capital city of Yaoundé. One of the institutional lessons that the WHO identified from the failures of malaria eradication programs was "the need for a previously well-established and functioning public health infrastructure."<sup>611</sup> The WHO thus advised that countries should develop this infrastructure in preparation to eventually pursue full-scale malaria eradication. The organization characterized this strategy as "pre-eradication." The organization defined the main purpose of a malaria pre-eradication program "to promote

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<sup>608</sup> WHO, M.E. Torfs, "Programme de Prééradication du Paludisme-Développement des Services de Santé de Base, » World Health Organization Regional Office for Africa, July 11, 1968, 2. WHO AFR/MAL 1968.

<sup>609</sup> *Journal Officiel de la République Fédéral du Cameroun*, 1 Juillet, 1962. Decree No. 62-DF-208 of the 16th of June 1962. Abane Mbomo held the classification of « médecin-africain. »

<sup>610</sup> CADN 744PO/1/691, Dr. S.P. Tchoungui à Monsieur le Ministre Délégué à la Présidence Chargé de l'Administration Territoriale des Finances et du Plan Yaounde, 20 Sept 1962, Objet : Demande exceptionnelle de subvention pour la lutte antipaludique.

<sup>611</sup> WHO "Report on the Third African Malaria Conference organized jointly by the Regional Office for Africa of the World Health Organization and the Commission for Technical Co-operation in Africa South of the Sahara," 1 February 1963, 4. WHO/MAL/376, AFR/MAL/9/62.

and contribute to the building up of those “necessary basic foundations,” which comprise two main components, or objectives: (a) the national malaria services; and (b) the public health infrastructure.”<sup>612</sup>

At the Yaoundé conference, Cameroonian officials, while expressing support for the WHO’s global strategy and Cameroon’s place in it, above all emphasized the imperatives of continuing with malaria efforts in a national context. Cameroonian President Ahidjo opened the conference and emphasized that, despite the failure of the eradication pilot program in southern Cameroon, people had experienced a “considerable decrease in infant mortality” over the course of the campaign and thus had new expectations for ongoing efforts:

So, in the course of my travels around the country, I find that prefects, parliamentarians and the local population are greatly disturbed by the discontinuance of insecticide spraying, of which they have learnt the value, and they ask me for chloroquine for their children. How can I explain to them that our country has not yet reached the stage of ‘operational maturity’ and that a pre-eradication programme, probably stretching over many years, must precede any eradication plan? What the people are worrying about is the fact that the number of malaria cases, as well as infant mortality, are increasing. Consequently, Gentlemen, the authorities in this country are wondering whether it is possible to wait for eradication to be effected on a world scale, and whether there are not grounds for taking measures at the national level straight away.<sup>613</sup>

Ahidjo’s comments indicate that he saw political imperatives in continuing with malaria efforts in Cameroon, regardless of how they related to larger global goals. More importantly, the idea of a globally-oriented timeline of “pre-eradication” presented potential obstacles to these national political imperatives.

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<sup>612</sup> WHO. “Report on the Third African Malaria Conference organized jointly by the Regional Office for Africa of the World Health Organization and the Commission for Technical Co-operation in Africa South of the Sahara,” 1 February 1963, 16. WHO/MAL/376, AFR/MAL/9/62.

<sup>613</sup> Ibid.

In the following months, Minister of Health Dr. Simon-Pierre Tchoungui similarly wrote that, while Cameroonian officials supported the WHO program outlined in the conference, eradication was still a “distant goal” and that malaria posed a serious public health problem in the country. He noted that “malaria morbidity was far more formidable than that of other conditions such as: leprosy, tuberculosis and treponematoses for which Cameroon benefits from bilateral and international assistance.”<sup>614</sup> Cameroonian officials thus staked their involvement with WHO programs going forward primarily in terms of the public health problems and politics of the nation.

The Cameroonian government in turn developed accords with the WHO based on the new strategy of malaria pre-eradication. Following the malaria conference in Yaoundé, the Cameroonian government signed a bilateral agreement with the WHO in December 1962. Most other independent African countries, by contrast, did not agree to adopt the pre-eradication programs for malaria advocated by the WHO.<sup>615</sup> The new plans for Cameroon focused on resumed DDT spraying in the former pilot zone around Yaoundé, provision of antimalarial drugs, and development of the public health infrastructure.<sup>616</sup> As part of planning for a new program of investment in basic health services in the Cameroon, the WHO sent a representative,

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<sup>614</sup> CADN 744PO/1/691, Dr. S.P. Tchoungui à Monsieur le Ministre Délégué à la Présidence Chargé de l’Administration Territoriale des Finances et du Plan Yaounde, 20 Sept 1962, Objet : Demande exceptionnelle de subvention pour la lutte antipaludique.

<sup>615</sup> James L.A. Webb, Jr, *The Long Struggle against Malaria in Tropical Africa* (New York: Cambridge University Press, 2014), 94.

<sup>616</sup> WHO “Report on the Third African Malaria Conference organized jointly by the Regional Office for Africa of the World Health Organization and the Commission for Technical Co-operation in Africa South of the Sahara,” 1 February 1963, 6. WHO/MAL/376, AFR/MAL/9/62.

Dr. M.E. Torfs, to Yaoundé in March of 1963 to conduct a country-wide survey of existing medical facilities.<sup>617</sup>

Through planning for a malaria pre-eradication program, Cameroonian officials dealt directly with the WHO and at times did not coordinate this work with the French fund for bilateral assistance, FAC. Minister of Health Tchoungui requested additional funding from FAC to support the malaria plan developed with the WHO, while recognizing that the lack of coordination:

Obviously it seems regrettable that the Executive Committee of FAC was not briefed on WHO's intentions in due course, but it was difficult for the Government of the Federal Republic of Cameroon to report on the negotiations (always long to finalize with the WHO) before they had been submitted.<sup>618</sup>

Despite the outsized role of French aid on the Cameroonian health administration in the early 1960s, these direct negotiations between the Cameroonian government and an international institution began to multiply the factors at play in shaping the health policy of Cameroon as a country, and its place in international health programs. The French meanwhile developed separate accords to support malaria work in Cameroon. In 1964, FAC funded a program for the distribution of anti-malarial drugs in schools in northern and southern Cameroon, as well as in

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<sup>617</sup> WHO AFR/MAL 1968. M.E. Torfs, "Programme de Prééradication du Paludisme-Développement des Services de Santé de Base, » World Health Organization Regional Office for Africa, July 11, 1968, 2.

<sup>618</sup> CADN 744PO/1/691, Dr. S.P. Tchoungui à Monsieur le Ministre Délégué à la Présidence Chargé de l'Administration Territoriale des Finances et du Plan Yaounde, 20 Sept 1962, Objet : Demande exceptionnelle de subvention pour la lutte antipaludique.

Yaoundé.<sup>619</sup> Torfs, the WHO representative, reported that the coordination in Cameroon between this French bilateral aid and the WHO was “practically inexistent.”<sup>620</sup>

### **Restructuring of the SGE and Rural Health**

The Cameroonian government first began to implement broader structural changes to the health administration, in line with WHO recommendations, through legislation in 1963. These changes to the structure of the health administration focused on fusing the curative and preventive medical services of Cameroon. The WHO called this nature of reform that it advocated “integration,” a term that became a flashpoint of conflict over the structuring of the health administration in Cameroon. According to the 1962 agreement between the WHO and Cameroon, a primary goal was to develop a network of rural health posts capable of providing adequate malaria screening and treatment in the ultimate pursuit of eradication.<sup>621</sup>

This plan called for a reorienting of the state medical resources of Cameroon in which most of the more highly-trained medical personnel, including both doctors and nurses, were concentrated in urban health centers.<sup>622</sup> In 1964, an equal number of state-employed doctors

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<sup>619</sup> WHO AFRO MAL 1968, Dr. M.E. Torfs, « Programme de Prééradication du Paludisme—Développement des Services de Santé de Base » 11 juillet 1968, AFR/MAL/94 ; AFR/PHA/42, 2. This program reflected the broader trend across Africa of the anti-malarial drug, chloroquine, becoming widely available in the 1960s. Webb, 102-105.

<sup>620</sup> World Health Organization Library, WHO AFR/MAL 1968. M.E. Torfs, “Programme de Prééradication du Paludisme-Développement des Services de Santé de Base, » World Health Organization Regional Office for Africa, July 11, 1968, 2.

<sup>621</sup> WHO AFRO MAL 1968, Dr. M.E. Torfs, « Programme de Prééradication du Paludisme—Développement des Services de Santé de Base » 11 juillet 1968, AFR/MAL/94 ; AFR/PHA/42, 1.

<sup>622</sup> In 1964-65, 64.6% of qualified state-employed para-medical personnel (Nurses with state diplomas (*Infirmiers diplômés d'Etat*) and certified nurses (*Infirmiers brevetés*) worked in urban hospitals. WHO M2-372-3 Came. *Programme for Malaria Eradication in Cameroon*, Dr. ME. Torfs, « Main Aspects of Planning for Basic Health Services in the Federal Republic of Cameroon (1966-1980), Project Cameroon-2, October 1966, 9. Nearly fifty percent (49.6%) of doctors in the country worked in the two cities of Yaoundé and Douala. Cameroun, Ministère des affaires économiques, *Plan quinquennal de développement économique et social : 2<sup>e</sup>, juillet 1966-juin 1971/Five-year plan of economic and social development, 2<sup>nd</sup>, July 1966-June 1971, 422.*

were available on one hand for the roughly 6% of the Cameroonian population living in the main cities of Yaoundé and Doula and on the other hand for the 94% of the population living outside these cities.<sup>623</sup> Auxiliary medical staff with less training and workers without any medical training primarily worked in rural areas, between dispensaries and the mobile teams.<sup>624</sup> Torfs of the WHO reported in his assessment of medical facilities in Cameroon that the sub-skilled personnel in these rural dispensaries rarely benefited from suitable supervision by a doctor, given the demands of those charged with this responsibility.<sup>625</sup> Moreover, the vast majority of medical personnel in the country worked in a capacity that the government characterized as “curative medicine” as opposed to “preventive medicine.”<sup>626</sup> Rural dispensaries thus provided very basic curative care, as opposed to preventive work done by the SGE of disease screening and prevention (such as vaccination), or sometimes treatment of

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<sup>623</sup> 64 state-employed doctors worked in Yaoundé and Douala in 1964-5, versus 63 in the rest of the country. Based on population, this worked out to 1 doctor per 75,000 people in rural areas. CADN 744PO/1/687. Dr. Guy Ferrand and J.P. Roubier, *Plan de Santé Publique: Rapport de Synthèse-Septembre 1966, République Fédérale du Cameroun*. The distribution of these doctors across rural areas moreover had vast regional differences. In the southern *Centre-Sud* administrative region, there was 1 doctor per 19,500 people versus 1 per 83,500 in the north.

<sup>624</sup> WHO M2-372-3 Came. *Programme for Malaria Eradication in Cameroon*, Dr. ME. Torfs, « Main Aspects of Planning for Basic Health Services in the Federal Republic of Cameroon (1966-1980), Project Cameroon-2, October 1966, 9. Torf described training for auxiliary medical personnel: “At present, the auxiliary personnel is instructed on the spot in the hospitals and dispensaries. This training satisfies in no way the most elementary instructional requirements and is wholly dependent on the initiative and the pedagogic abilities of the doctor responsible for it.”

<sup>625</sup> WHO, M2-372-3 Came. *Programme for Malaria Eradication in Cameroon*, Dr. ME. Torfs, « Main Aspects of Planning for Basic Health Services in the Federal Republic of Cameroon (1966-1980), Project Cameroon-2, October 1966, 13. The supervision of rural dispensaries fell under the responsibility of a “Divisional Director of Public Health,” the head of an administrative unit that was also responsible for the hospital of the division. Torfs reported, “Owing to this situation and to the lack of doctors, the Divisional Director has in fact no time for a suitable supervision of the rural dispensaries, taking into account his hospital duties. Furthermore, in some cases conflicts are arising between the Divisional Director of Public Health and the mayors who do not accept easily to have their Local Council’s dispensaries supervised by a representative of the Central Government.”

<sup>626</sup> 89.1% of medical personnel worked in curative medicine as opposed to 10.8% in preventive. Dr. ME. Torfs, « Main Aspects of Planning for Basic Health Services in the Federal Republic of Cameroon (1966-1980), Project Cameroon-2, October 1966, 9.

transmissible diseases. The SGE in turn followed circuits of work within its prescribed sectors that overlapped with areas where there were rural dispensaries, but it rarely worked in coordination with these facilities.<sup>627</sup>

The Cameroonian government thus began pursuing reforms to create closer coordination between curative and preventive measures in rural areas, which entailed a re-envisioning of the place of the mobile teams in the overall work of the public health administration. These reforms began only on a more conceptual level in the early 1960s, but they catalyzed a debate over their merits within Cameroon over the course of the decade. In 1963, the Cameroonian government began initiating reforms to create a new section of the health administration, *Le Service des Grandes Endémies et de la Médecine Rurale*, aiming to ultimately integrate the work of rural dispensaries and the SGE.<sup>628</sup> A cornerstone of this change would be SGE doctors, the heads of SGE sectors, taking over responsibility for the oversight of rural dispensaries. Dr. Happi, the Director of Health in 1963, reasoned that SGE doctors were in the best position to provide oversight of these dispensaries, given their existing work in touring areas through their oversight of mobile health teams.<sup>629</sup>

Dr. Happi, Dr. Torfs of the WHO, and SGE doctors working in Cameroon met in August of 1964 to discuss the implications of these changes, and this gathering became an annual occurrence to discuss changes to the rural health administration. In this meeting, Dr. Happi and

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<sup>627</sup> CADN 744PO/1/687. Dr. Guy Ferrand and J.P. Roubier, *Plan de Santé Publique: Rapport de Synthèse-Septembre 1966, République Fédérale du Cameroun*.

<sup>628</sup> CADN 744PO/1/687. Dr. Guy Ferrand and J.P. Roubier, *Plan de Santé Publique: Rapport de Synthèse-Septembre 1966, République Fédérale du Cameroun*.

<sup>629</sup> SHD 2013 ZK 005 433, « Symbiose Santé Publique Grandes Endémies » (Extrait du Compte-rendu des journées d'études des médecins des Grandes Endémies, Yaoundé, 17-22, Août 1964, Docteur Menard).



Dr. Torfs stood in the position of explaining these changes to the French military SGE doctors, and advocating for the vision of this new arrangement. Happi specifically began in this meeting to develop a position as a mediator between the WHO and SGE doctors, a role that he would continue to play at points throughout the 1960s.

Although some SGE doctors pointed to few potential benefits to this new plan, many cast the intended reforms as a fundamental reordering of the purpose and work of the mobile health team service as it existed. Dr. Sébastien Garrigue, Deputy Director the SGE, asked pointedly, “Can we now conclude that the specific action of the *Service des Grandes Endémies* is at an end?” He warned that if the service was eliminated or altered, it would likely have to be reconstituted in the future to confront new disease threats.<sup>630</sup>

Happi expressed surprise at the pushback for the SGE doctors to the plan for “integration” and asserted the necessities of making changes to the existing system.<sup>631</sup> Although, Happi in other forums celebrated upholding the legacy of Jamot, here he also insisted upon the need for reform in light of changing circumstances within Cameroon.

.. the current SGE must assume the role we expect of it. It is not a question of retaining the same principle that JAMOT had instituted in the SHMP... There were epidemics at that time that were absolutely necessary to be controlled by mobile circuits. Today, these epidemics no longer exist with the same intensity, but these epidemics have become endemic. To treat bilharzia, smallpox or trypanosomiasis, do we need a mobile team? Can not one radiate from fixed bases? And cannot these fixed bases be dispensaries?<sup>632</sup>

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<sup>630</sup> SHD 2013 ZK 005 433, « Symbiose Santé Publique Grandes Endémies » (Extrait du Compte-rendu des journées d'études des médecins des Grandes Endémies, Yaoundé, 17-22, Août 1964, Docteur Menard).

<sup>631</sup> Ibid.

<sup>632</sup> Ibid.

As Happi asserted this new framework, the meeting highlighted the delicate arrangements of authority produced through the combination of Cameroonian political independence and the ongoing hold of French military doctors on the mobile health service. Garrigue asserted that doctors should have been consulted before these changes were made, but he also expressed the bottom-line subordination of the SGE doctors to work within the framework of the Cameroonian government, given that the changes were already legislatively instituted. He concluded, “There is absolutely no question and there has been no question of us fighting it; we are the ‘executants.’”<sup>633</sup> This meeting also highlighted new working dynamics that these changes created between Cameroonian health officials, SGE doctors and the WHO. Dr. Happi presented a united cause with Dr. Torfs in reforming the Cameroonian health system, and while recognizing the French SGE doctors as those who would be the front line of this change, he asserted that the French doctors would need to adapt in the coming years to a new health plan.

The Cameroonian government further institutionalized these reforms through legislation in 1965. This legislation charged the *Service des Grandes Endémies et de la médecine rurale* with both curative and preventative medicine through rural health centers and the surrounding areas.<sup>634</sup> The mandate of this service would extend behind the detection and prevention of transmissible diseases to also include responsibility for preventive health aimed specifically at mothers and children in rural areas, at sanitation, and health education.<sup>635</sup> These plans for

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<sup>633</sup> SHD 2013 ZK 005 433, « Symbiose Santé Publique Grandes Endémies » (Extrait du Compte-rendu des journées d’études des médecins des Grandes Endémies, Yaoundé, 17-22, Août 1964, Docteur Menard).

<sup>634</sup> WHO AFRO MAL 1968, Dr. M.E. Torfs, « Programme de Prééradication du Paludisme—Développement des Services de Santé de Base » 11 juillet 1968, AFR/MAL/94 ; AFR/PHA/42, 7.

<sup>635</sup> WHO AFRO MAL 1968, Dr. M.E. Torfs, « Programme de Prééradication du Paludisme—Développement des Services de Santé de Base » 11 juillet 1968, AFR/MAL/94 ; AFR/PHA/42, 9.

reform of the health system moreover became enshrined in Cameroon's second development plan, for 1966-1971, with Dr. Torf's study of the existing health facilities in Cameroon deeply shaped the framing of health issues in this report.

The plans for basic health services called for further restructuring of the administrative organization of the SGE and of preventive health work. In 1964, the SGE in East Cameroon worked through a division of the federated state into 14 sectors, each encompassing a main town that the SGE used as a base. Each sector came under the direction of a medical officer, which at this time still were still primarily French military doctors. This medical officer in turn oversaw the work of mobile teams to travel circuits for screening, prevention and treatment across the villages of the sector.<sup>636</sup> By contrast, the administration of hospital and dispensaries worked through the administrative unit of the Division, with the Divisional Director of Public Health in charge.<sup>637</sup>

In 1967, the Cameroonian government designated new administrative units for rural health, dividing the country into 24 sectors of *Grandes Endémies et de la Médecine Rurale*, marking a change from the previous 14 sectors of the SGE structure.<sup>638</sup> The plans to reform the health system revolved around the creation of Departmental Centers of Preventive Medicine (Centre départemental de médecine preventive, CDMP) headed by a doctor. The former SGE sector base would become the "Centre Départemental de Médecine Préventive," a headquarters

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<sup>636</sup> WHO M2-372-3 Came. *Programme for Malaria Eradication in Cameroon*, Dr. ME. Torfs, « Main Aspects of Planning for Basic Health Services in the Federal Republic of Cameroon (1966-1980), Project Cameroon-2, October 1966, 13.

<sup>637</sup> WHO M2-372-3 Came. *Programme for Malaria Eradication in Cameroon*, Dr. ME. Torfs, « Main Aspects of Planning for Basic Health Services in the Federal Republic of Cameroon (1966-1980), Project Cameroon-2, October 1966, 13.

<sup>638</sup> *Rapport Final de la Deuxième Conférence Technique, Yaoundé du 30 janvier au 3 février 1967, Tome II. « Le Médecine Préventive au Cameroun »* par le Dr. Delas, 314.

of sorts for all the rural health work in the area. Each CDMP would include a mobile team for disease screening and vaccination, however the new structure focused primarily on a new model of mobile health work. Under the umbrella of this center fell health facilities, including existing dispensaries, which would be classified as either “Centres de santé développés” and “Centres de santé élémentaire.” Each center would be headed by a nurse and serve as a base for “mobile” personnel charged with going directly to peoples’ homes in the area of the Centre de santé. This thus marked a change from the mobile health team model of assembling people at a specific time for all forms of preventive intervention. In addition to the explicitly mobile personnel, the idea was that all personnel who previously worked only in dispensaries would also have a mobile aspect to their responsibilities.<sup>639</sup> This plan thus did not diminish the need for “mobile” health intervention in Cameroon, but reordered the focus, staffing and supervision of this kind of work. Most importantly, it structurally integrated this work in the functioning of ‘static’ health posts.

In theory, each of these rural health sectors would be led by a doctor who would work alongside another doctor in charge of the larger hospitals and health structures in the area. At the time of the change, however, Cameroon did not have enough doctors to fill all of these positions. Only 10 sectors in East Cameroon, designated as ‘type A’ could be equipped with the two head doctors. Nine of the sectors had only one doctor to oversee both the hospital and rural health affairs.<sup>640</sup> Dr. André Delas of the SGE characterized the success of the reforms as largely

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<sup>639</sup> WHO AFRO MAL 1968, Dr. M.E. Torfs, « Programme de Prééradication du Paludisme—Développement des Services de Santé de Base » 11 juillet 1968, AFR/MAL/94 ; AFR/PHA/42, 7-8.

<sup>640</sup> *Rapport Final de la Deuxième Conférence Technique, Yaoundé du 30 janvier au 3 février 1967, Tome II.* « Le Médecine Préventive au Cameroun » par le Dr. Delas, 315. In 9 “type B” sectors, a single doctor would oversee affairs at both the hospital and rural level. Finally, in 5 “type C” sectors, “le Médecin de Secteur s’occupe de plusieurs départements dotés chacun d’un Médecin-Hôpitaux’

based in this organization of personnel; where there were two head doctors, the work was progressing, but where there was one he saw an almost total failure of reforms. He painted a picture of a surgeon, uninterested in public health, being in the position of overseeing preventive medicine and being simply unable or unwilling to fulfill the role.<sup>641</sup>

In the sectors that were more fully functioning, some key operational changes occurred. For one, dispensaries (now called health centers) were inspected frequently. The method of treating leprosy also was shifted from being mobile health team work to the job of a nurse connected to the health center who would travel around the area by bike. Another important change involved increasing state oversight and standardization of medication and equipment for dispensaries.<sup>642</sup> The mobile teams of the SGE remained in place, with the plan that they would remain so for disease screening and vaccinations, until “total coverage” was achieved with the new rural health system.<sup>643</sup>

This reorganization could not happen en masse, and the Cameroonian government worked with the WHO to focus on implementing these changes first in discreet pilot zones within the country, called *Zone de Demonstration d'Action de Santé Publique* (DASP). The government ultimately designed six DASP zones representing different geographic, ecological, and social conditions within the countries.<sup>644</sup> The first DASP zone of Nyong et Kellé launched

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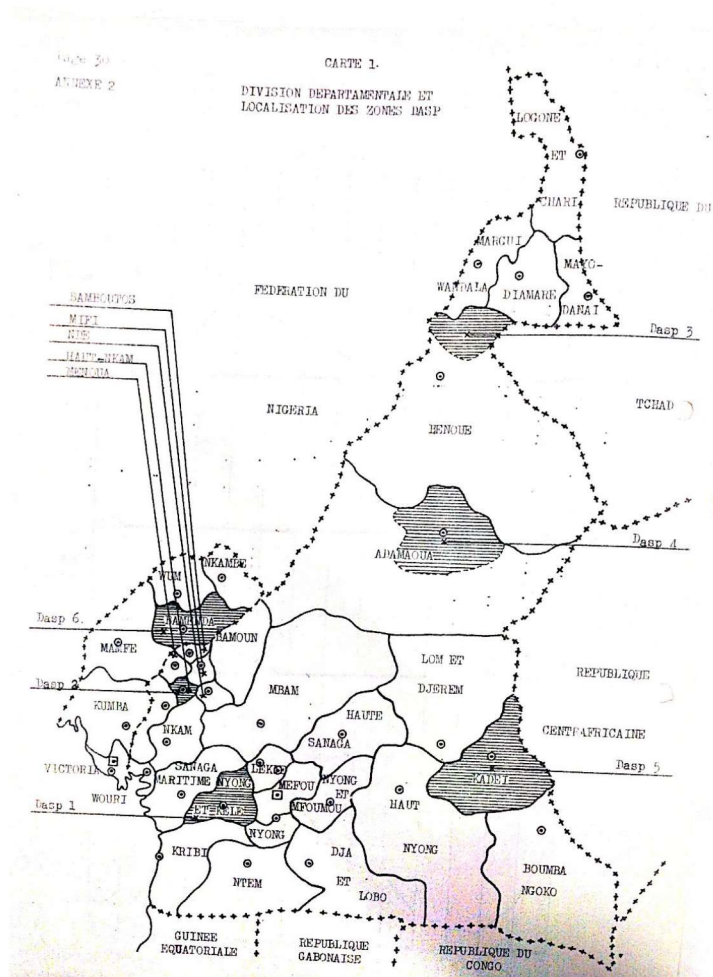
<sup>641</sup> *Rapport Final de la Deuxième Conférence Technique, Yaoundé du 30 janvier au 3 février 1967, Tome II. « Le Médecine Préventive au Cameroun »* par le Dr. Delas, 315.

<sup>642</sup> *Rapport Final de la Deuxième Conférence Technique, Yaoundé du 30 janvier au 3 février 1967, Tome II. « Le Médecine Préventive au Cameroun »* par le Dr. Delas, 316.

<sup>643</sup> *Rapport Final de la Deuxième Conférence Technique, Yaoundé du 30 janvier au 3 février 1967, Tome II. « Le Médecine Préventive au Cameroun »* par le Dr. Delas, 318.

<sup>644</sup> WHO AFRO MAL 1968, Dr. M.E. Torfs, « Programme de Prééradication du Paludisme—Développement des Services de Santé de Base » 11 juillet 1968, AFR/MAL/94 ; AFR/PHA/42, 8. The six zones were in the following areas. 1) Nyong et Kellé, 2) Haut-Nkam, 3) Guider, 4) Ngoundere, 5) Kadei and 6) Bamenda.

in January 1967 and the second of Haut-Nkam in July 1967.<sup>645</sup> The first two DASP zones began operation with a doctor in charge of each zone and aided by a head nurse. UNICEF furnished each with a vehicle for their work.<sup>646</sup>



Map of DASP zones. WHO Archives, CAE-SHE-001 Jkt 1-Development of Basic Health Services, 1967-1969.

<sup>645</sup> WHO AFRO MAL 1968, Dr. M.E. Torfs, « Programme de Prééradication du Paludisme—Développement des Services de Santé de Base » 11 juillet 1968, AFR/MAL/94 ; AFR/PHA/42, 8.

<sup>646</sup> WHO AFRO MAL 1968, Dr. M.E. Torfs, « Programme de Prééradication du Paludisme—Développement des Services de Santé de Base » 11 juillet 1968, AFR/MAL/94 ; AFR/PHA/42, 12. While updating its bilateral agreements with the WHO in 1965 and 1967, the Cameroonian government also signed a tripartite agreement with the WHO and UNICEF in August 1966 for the development of basic health services.

One of the first goals in the zones was to retrain existing medical personnel for “itinerant duties” surrounding existing dispensaries.<sup>647</sup> Thirteen mobile workers were posted in DASP zone 1 and six in DASP zone 2.<sup>648</sup> The mobile agents would be charged with home visits focused on tasks including malaria screening, leprosy treatment and health education.<sup>649</sup> The training of these first mobile agents concluded in October 1967, and Dr. Happi held a ceremony in Yaoundé with the trainees and with WHO officials marking its conclusion, characterizing this new approach as something never before attempted in Equatorial Africa.<sup>650</sup> The goal was to launch all of the six DASP zones by 1970, thereby covering roughly a tenth of the territory and a seventh of the population. These methods would then be extended out from the DASP zones based on experiences gathered.

In a report that Torfs prepared on the rural health reforms, he articulated what he saw as the place of the mobile health teams in this new schema:

The author believes that despite the integration of static and mobile medicine through the introduction of mobile agents (itinerants) in health centers' areas of influence, mobile teams, although in very small numbers, should be maintained at least at the scale of the region. It is difficult to imagine, before long, that the mass

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<sup>647</sup> WHO AFRO MAL 1963-1967, « The Malaria Eradication Programme in the African Region,” 19 February 1965, AFR/MAL/67, 12.

<sup>648</sup> WHO AFRO MAL 1968, Dr. M.E. Torfs, « Programme de Prééradication du Paludisme—Développement des Services de Santé de Base » 11 juillet 1968, AFR/MAL/94 ; AFR/PHA/42, 13. The suggested plans for the DASP zones had called for a greater number of mobile personnel: 22 for DASP zone 1 and 27 for zone 2.

<sup>649</sup> WHO AFRO MAL 1968, Dr. M.E. Torfs, « Programme de Prééradication du Paludisme—Développement des Services de Santé de Base » 11 juillet 1968, AFR/MAL/94 ; AFR/PHA/42, 13. Other tasks would include screening for transmissible diseases and direction of cases to departmental hospitals, basic emergency care (such as snake bites), and collection of demographic statistics such as births and deaths.

<sup>650</sup> National Archives of Cameroon, Yaoundé. *L'Agence Camerounaise de Presse*, « Cérémonie de Clôture du Stage de Formation des Itinérants des Zones de Démonstration d'Action en Santé Publique, » No. 244 du Mercredi 25 Octobre 1967.

campaigns (emergency prospecting and vaccinations) can be carried out by mobile agents.

Torfs reasoned that the mobile agents still had to be recruited in the years to come and would be not be equipped to maintain the material needed for mass vaccination campaigns. Moreover, he saw the mobile agents as playing a role in preparing for mass vaccination campaigns by informing people and ensuring cooperation.<sup>651</sup> The plans for basic health services thus did not call for an immediate end to the mobile health teams.

This plan did call, however, for a major increase of the Cameroonian health budget, which became another source of contention among SGE doctors who characterized these increases as unrealistic. The Cameroonian government estimated that the investment in basic health services from 1966-1971 would require a near doubling of the operating health budget, and a reorientation of greater resources towards preventive health.<sup>652</sup> In addition to plans for an increase in operating budget, the government oversaw a substantial investment in building up the health infrastructure of the country during this period.<sup>653</sup> Behind operational claims about what was needed or possible among Cameroonian, French and WHO officials, however was

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<sup>651</sup> WHO AFRO MAL 1968, Dr. M.E. Torfs, « Programme de Prééradication du Paludisme—Développement des Services de Santé de Base » 11 juillet 1968, AFR/MAL/94 ; AFR/PHA/42, 15.

<sup>652</sup> In 1964/1965 the public health budget of Cameroon amounted to 1,922 million CFA, roughly 10.4% of the Federal budget. Moreover, hospitals in Yaoundé and Douala took up roughly the same amount of funds as all of preventive medicine efforts combined (276 million and 263 million respectively). The WHO recommend at this time that public health budgets should constitute 15% of an overall national budget. The projected costs for the investment in basic health services would raise the public health budget to 4,000 million CFA by 1970. Ministère des affaires économiques, *Plan quinquennel de développement économique et social : 2<sup>e</sup>, juillet 1966-juin 1971/Five-year plan of economic and social development, 2<sup>nd</sup>, July 1966-June 1971*.

<sup>653</sup> The health investment program for 1966-1971 totaled 3,765 million CFA. The largest external contributor to this program was the European Development Fund, with a grant of 1,942 million CFA. An additional 450 million derived from other international sources. 1087 million of this investment was allocated for preventive and rural medicine establishments. The rest of the money would go towards hospitals. Ministère des affaires économiques, *Plan quinquennel de développement économique et social : 2<sup>e</sup>, juillet 1966-juin 1971/Five-year plan of economic and social development, 2<sup>nd</sup>, July 1966-June 1971*.



also a fundamental debate over expertise and authority over the landscape of rural health in independent Cameroon.

### **OCEAC and Basic Health Services**

These debates over integration continued in the following years and became a significant point of controversy. In the forum of OCEAC, Secretary General Rene Labusquière became a vehement critic of the WHO-led reforms, arguing that they were unrealistic and would upend the necessary role of the mobile health teams. Moreover, through OCEAC meetings, the issue moved beyond one of concern for the Cameroonian national administration to being a broader issue about the role of the WHO in Africa and the legacy of systems already in place in former French colonies. Through OCEAC, Labusquière asserted a claim to be the guardian of preventative medicine, and of rural health in Cameroon and other OCEAC countries, based on his long career with the mobile health team service dating to the colonial period.

Dr. Happi, in his role as both the Commissioner General of Health of Cameroon and the first President of OCEAC starting in 1965 adopted a role of negotiator, seeking to simultaneously affirm the work of both the French SGE doctors and the WHO in Cameroon. In OCEAC meetings throughout the late 1960s, he argued that these reforms were not meant to dismantle, but rather to adapt and revitalize, the work of the mobile health teams. In so doing, he thus sought to reconcile the financial, material and technical assistance from France and the WHO to Cameroon, even when these visions of assistance were in disaccord.

Other Cameroonian health officials similarly bolstered the position of the WHO on reform for Cameroon's health system. Dr. Samuel Abane, head of the National Malaria Eradication Service in Cameroon, also advocated for WHO-led reforms to rural health in the first technical meeting of OCEAC in 1965. Noting that Cameroon was the only OCEAC

member country to have adopted a pre-eradication program in conjunction with the WHO, he urged the other member countries to “come out of their lethargy and commit resolutely to this long-term undertaking.”<sup>654</sup>

The claims of Cameroonian, French and WHO representatives to influence over the Cameroonian health system continued to present a politically charged situation. In these OCEAC meetings, French military doctors struck a particular tone of being vocal critics of the WHO, while emphasizing their subordinate role in the decisions of the Cameroonian government. The OCEAC meetings thus created a forum for a performance of honoring Cameroon’s sovereignty, while French military doctors at the same time sought to exert major influence on the development of international health programming in the country and other OCEAC member states. Dr. Garrigue, head of the SGE in Cameroon, expressed these sentiments, which Dr. Aujoulat, in his role as a delegate of the French Ministry of Health confirmed this position:

We are not responsible for the health policy of these countries, we are simply at the service of this policy, which is the integral responsibility of the states, and our role consequently is to be the instigators...the servants of the health policy the most suitable and the most easily achievable in Africa.<sup>655</sup>

That said, Labusquière framed the reforms as an ongoing threat to the future of the mobile health team service and defended the service as upholding a privileged knowledge of health needs in Africa. Labusquière moreover placed the creation of the new system for rural

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<sup>654</sup> *Rapport Final de la Première Conférence Technique de l’O.C.C.G.E.A.C.*, Yaoundé du 7 au 11 Décembre 1965, Tome I, 102-104.

<sup>655</sup> *Rapport Final de la Première Conférence Technique de l’O.C.C.G.E.A.C.*, Yaoundé du 7 au 11 Décembre 1965, Tome II, 401.

medicine as but a new development in a long history of opposition to the mobile health service. Echoing debates about the 1950s about the autonomy of the mobile health team service, he pointed to a history of opposition to the service among French doctors of the colonial medical service. The specific threats he saw to the existing system similarly echoed the concerns of the 1950s about the “balkanization” of the service; Labusquière here pointed to the danger of “departmentalization” of the SGE sectors.<sup>656</sup>

Labusquière also contrasted the work of the SGE doctors with African doctors who focused primarily on curative medicine.<sup>657</sup> In defending a particular professional ethos of the SGE, Labusquière thereby undermined the authority of African doctors and health officials over knowledge of the *terrain*. He claimed a specific kind of expertise garnered through the work of the mobile health teams, a claim which relatively few doctors could make in the medical administration. He expressed total mystification as to the reason for this opposition, and rooted this confusion in the image of the rugged SGE doctor working tirelessly, and alone, in the “bush”:

Let us say that those who have worked there for years...who know that in the bush they are the only ones, absolutely the only ones to do something...this systematic denigration, is more than discouraging, more than sickening, it is incomprehensible.<sup>658</sup>

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<sup>656</sup> *Rapport Final de la Deuxième Conférence Technique de l'O.C.E.A.C.*, Yaoundé du 30 janvier au 3 février 1967, Tome II, 332.

<sup>657</sup> *Rapport Final de la Première Conférence Technique de l'O.C.C.G.E.A.C.*, Yaoundé du 7 au 11 Décembre 1965, Tome II, 328. « Or, on sait que les Docteurs en Médecine Africains sont, dans la grande majeure de cas, a vocation chirurgicale, et en général, intéressés par la médecine curative, citadine, individuelle. »

<sup>658</sup> *Rapport Final de la Deuxième Conférence Technique de l'O.C.E.A.C.*, Yaoundé du 30 janvier au 3 février 1967, Tome II, 327-328.

Labusquière reserved a particular ire for the “most important” opposition to the SGE represented by the WHO. He characterized the WHO’s opposition to the SGE as “doctrinal, on principle, irreducible: the *Service des Grandes Endémies* must disappear.”<sup>659</sup> Labusquière framed the conflict between the WHO and the SGE as one of idealism versus the reality “on the ground.” His colorful language describing the WHO illustrated this central complaint:

The WHO is a great lady who is not in a hurry. She does not have the day-to-day responsibility to heal, on the ground, all those who are suffering. Dispensing advice, she does not have to face every day the almost insoluble problems faced by bush doctors: being everywhere at the same time and caring for people without having the means. ....It is only this ideal solution that interests her... To judge her way of acting, allow me a picture. I picture to myself this great lady WHO on the shore of a river. In this river a man drowns. Instead of rushing to her aid, this great lady immediately sets in motion all her immense influence to create swimming schools everywhere, in order to no longer be faced with the distressing spectacle of a drowning man. And to the astonished witnesses, she adds, ‘what is the point of drawing this man to shore, so long as he may find venomous serpents, which you must at once try to destroy everywhere. ...’ It is up to us, who are on the ground, to understand this point of view and not want to immediately put into practice what the WHO is planning for a still distant future. If we understand this, we will no longer struggle with the WHO and we will avoid errors due to poorly understood haste.<sup>660</sup>

Labusquière argued that, without adequate resources and personnel to fully realize the rural health reforms, the result would be that curative medicine establishments would absorb the resources intended for preventive medicine.<sup>661</sup> Moreover, he held that it was impossible for one person to oversee both the “santé de masse” and individual medical cases. He argued that these

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<sup>659</sup> *Rapport Final de la Deuxième Conférence Technique de l’O.C.E.A.C.*, Yaoundé du 30 janvier au 3 février 1967, Tome II, 328.

<sup>660</sup> *Rapport Final de la Deuxième Conférence Technique de l’O.C.E.A.C.*, Yaoundé du 30 janvier au 3 février 1967, Tome II, 329.

<sup>661</sup> *Rapport Final de la Deuxième Conférence Technique de l’O.C.E.A.C.*, Yaoundé du 30 janvier au 3 février 1967, Tome II, 333.

changes could only be made very slowly, in places where the resources were available. But before these changes became fully realizable, he saw the SGE as the only way to assure preventive medicine.<sup>662</sup> Moreover, Labusquière argued that the WHO sought to reform the SGE, not because of the outcomes of the service, but because of its origins in the colonial period. Labusquière did not frame the methods of the teams as ‘colonial’ in nature, but rather argued that the fact that they had originated under colonial rule made them a target of reform.<sup>663</sup>

Reports from some areas of Cameroon, however, indicated that people vastly preferred visiting nearby dispensaries to the visit of a mobile health team. A SGE sector head reported on work of the teams in Foumban in 1967:

Increasing enthusiasm for health centers and refusal by the population of systematic visits. Everyone, even the sick, on the day of prospecting or vaccination/consultation often prefers to go to the nearest health center ...<sup>664</sup>

A mobile team also attempted to undertake a disease screening in the area of Foyum, which also had a *Centre de Santé*. The team reported that whereas people arrived en masse to be vaccinated when the team arrived, only 19.6% of people accepted being examined for disease, and the rest of the people fled.<sup>665</sup> The uneven reforms to rural medicine, which facilitated both the development of new rural health centers and the ongoing work of mobile teams thus created

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<sup>662</sup> *Rapport Final de la Deuxième Conférence Technique de l'O.C.E.A.C.*, Yaoundé du 30 janvier au 3 février 1967, Tome II, 334.

<sup>663</sup> *Rapport Final de la Première Conférence Technique de l'O.C.C.G.E.A.C.*, Yaoundé du 7 au 11 Décembre 1965, Tome II, 330.

<sup>664</sup> *O.C.E.A.C, Activité des Services des Grandes Endémies des Etats-Membres, Synthèse Globale, Rapport Annuel, 1967*, 4.

<sup>665</sup> *O.C.E.A.C, Activité des Services des Grandes Endémies des Etats-Membres, Synthèse Globale, Rapport Annuel, 1967*, 4.

new opportunities through which Cameroonians could show how and in what fashion they preferred biomedical intervention

Happi, in response to these critiques by Labusquière, sought to chart a conciliatory path based all at once in the recognition of a new political moment in Cameroon, and an affirmation of both the SGE and the WHO in this moment. Happi's comments in OCEAC meetings reveal that he saw the growth of health centers as central to a new sense of assurance of well-being for Cameroonians. He argued that it was the network of dispensaries, the presence of a nurse, that "brought to our population moral security...which was indispensable to a happy life."<sup>666</sup> Notably, however, Happi did not frame this advocacy of health centers as rooted in a break with the colonial past or with the SGE. In the early stages of these OCEAC debates, Happi rather emphasized the centrality of the SGE to these reforms. He argued that the plan for rural medicine in Cameroon "was only a question of giving new life to the *Service des Grandes Endémies*, which remained the base of all reform."<sup>667</sup>

At the same time, Happi worked to assure present WHO representatives of their welcome presence in Cameroon and in OCEAC. Opening the OCEAC technical conference in 1968, Happi referred to Labusquière's comments about the WHO being a "great lady" and assured its representatives that the organization was "precious and dear" to Cameroon.<sup>668</sup> By 1969, Happi sharpened his tone, warning that if OCEAC wanted to remain an "avant-garde"

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<sup>666</sup> *Rapport Final de la Première Conférence Technique de l'O.C.C.G.E.A.C.*, Yaoundé du 7 au 11 Décembre 1965, Tome II, 326. Quoted by Labusquière from previous OCEAC meeting in Fort-Lamy.

<sup>667</sup> *Rapport Final de la Première Conférence Technique de l'O.C.C.G.E.A.C.*, Yaoundé du 7 au 11 Décembre 1965, Tome II, 419.

<sup>668</sup> *Rapport Final de la Troisième Conférence Technique de l'O.C.E.A.C.*, Yaoundé du 24 au 27 janvier 1968, Tome I, 11.

organization, it would have to contribute to this development of rural medicine in order to advance the economic development of Africa.<sup>669</sup>

OCEAC ultimately advocated a counter-plan to that of the WHO, asserting that CDMP posts only be set up when two fully-trained doctors were available to head them, with seniority given to the doctor in charge of preventive medicine.<sup>670</sup> OCEAC thus offered a particular forum for French SGE doctors to challenge WHO reform and to propose counter-reforms at a regional scale.<sup>671</sup> These recommendations did not fundamentally alter the direction of reforms pursued by the Cameroonian Ministry of Health, but they did create a space of debate beyond the bilateral relationships of health assistance between Cameroon and France, and that of Cameroon and the WHO. It was in this space that French SGE doctors took their sharpest aims at the influence of the WHO in Cameroon and in other OCEAC member countries.

This conflict between Cameroonian officials, French SGE doctors and WHO representatives had not resolved by the late 1960s.<sup>672</sup> The most dramatic attempts to reform the Cameroonian health system, however, remained limited to the demonstration pilot zones and the mobile health teams still played a central role in vaccination work in the country. The focus on

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<sup>669</sup> *Rapport Final de la Quatrième Conférence Technique de l'O.C.E.A.C.*, Yaoundé du 21 au 25 janvier 1969, Tome I, 11.

<sup>670</sup> *Rapport Final de la Deuxième Conférence Technique de l'O.C.E.A.C.*, Yaoundé du 30 janvier au 3 février 1967, Tome II, 334, 339.

<sup>671</sup> Dr. Pierre Richet, Secretary General of OCEAC's West African counterpart, similarly pushed back against these WHO recommendations. These debates referenced: *Rapport Final de la Deuxième Conférence Technique de l'O.C.E.A.C.*, Yaoundé du 30 janvier au 3 février 1967, Tome II, 331.

<sup>672</sup> The topic of integration remained so important for Labusquière that he wrote a book about it in the early 1970s after he had left his position at OCEAC. In this work, he reiterated his main positions on the subject, but played down the idea that he had been in direct conflict with the ideas of the reforms suggested by the WHO. René Labusquière, *Santé Rurale et Médecine Préventive en Afrique : Stratégie à Opposer Aux Principales Affections*, (Le François, Paris, 1975, 2<sup>nd</sup> edition)

rural medicine and its reconceptualization by WHO and Cameroonian health officials also, however, opened new avenues of medical training within the country that sought to advance the goals of rural health.

### **A New Age of Medical Education**

The reconceptualization of the rural health system in Cameroon raised questions about how to properly train medical personnel to work in this system. In the late 1960s, the Cameroonian government instituted new programs to train medical staff through the DASP zones, to implement public health training in existing schools, and to develop an entirely new medical and public health training center in Yaoundé. The reforms represented some of the most concrete and powerful changes to emerge from the WHO focus on basic health services.

First, the government created plans to focus on preventive and public health training for existing medical workers and students. For example, all doctors would undergo a seven day public health orientation “on the basis of experience gained through DASPS” while para-medical personal would receive a ten day public health training in the DASPS themselves. In 1970, for example, the town of Eséka in DASP zone 1 served as the site of training for doctors and nurses serving as departmental heads for the *Service des grandes endémies et de la médecine rurale*.<sup>673</sup> Meanwhile, public health training would be incorporated into the curriculum of the six para-medical training schools in Cameroon for the first time from 1966 forward.<sup>674</sup> As Cameroonian doctors began to serve as the heads of zones of *Service des*

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<sup>673</sup> NAC, *L'Agence Camerounaise de Presse*, « Stages des Médecins et Chefs des Zones de Démonstration et d'action de Santé Publique » No. 118 du jeudi 28 mai 1970. The training took place from May 11-16 1970.

<sup>674</sup> NAC Buea. Sc/a/1964/9. 3 December 1965. Memo. To: Africa Desk, Programme Division, New York. From: UNICEF Representative, Brazzaville. Subject: Explanatory note of the recommendation to the Executive Board in May 1966-Basic Health Services-Cameroun. These institutions included the 1) Centre d'Instruction Médicale, Ayos. 2) Government School of Nursing and Midwifery, Victoria and Bamenda, 3) Ecole Catholique d'Infirmières,



*grandes endémies et de la médecine rurale*, such as Dr. Théodore Botétéme in Nyong et Kellé in 1970, these trainings created a new professional milieu rooted in the basic health services reform.<sup>675</sup>

The WHO also advocated for the Cameroonian government to create a new medical school in Yaoundé, which would train workers for a focus on public health and for rural health. The WHO ultimately influenced the Cameroonian government to develop this new model, rather than create a medical school according to French models similar to that in place in Dakar, Senegal.<sup>676</sup> The Centre Universitaire des Services de la Santé (CUSS)/the University Center for Health Sciences would prepare students to work in Cameroon, in line with the resources and needs of the country. The school would thus seek to train both doctors and paramedical professionals equipped to advance the basic health services model. For example, the curriculum would focus not on training specialists, but on general practitioners. Moreover, it would focus on teaching on “African” health problems, and move more quickly through health problems found in more “developed” countries.<sup>677</sup> The first students began at the new school built on the campus of the Federal University in Yaoundé in 1969.

The establishment of CUSS, particularly in its break with French educational models, also created new openings to bridge the medical systems of East and West Cameroon. The

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Yaoundé, 4) Ecole d’Infirmières Emile-Sakar, Doula, 5) Missionary Schools of Nursing and Midwifery (Cameroon Baptist Mission Hospital, Bango, St Elizabeth’s Hospital, Shishong, Nsaw). Preparations were also being made to open a nurse-midwifery school in Garoua in 1967.

<sup>675</sup> NAC, *L’Agence Camerounaise de Presse*, « Stages des Médecins et Chefs des Zones de Démonstration et d’action de Santé Publique » No. 118 du jeudi 28 mai 1970.

<sup>676</sup> Interview with Dr. Thomas Nchinda, May 22, 2014. Founex, Switzerland.

<sup>677</sup> « L’Enseignement au Centre Universitaire des Services de la Santé (CUSS) de Yaoundé, par le Professeur Tran-Dinh-De. *Quatrième Conférence Technique de l’O.C.E.A.C., Yaoundé du 21 au 25 janvier 1969*, 524-525.

school created new needs in the country for medical professors, and anglophone Cameroonian doctors ultimately played a powerful role in shaping the institution in its infancy. This central cohort of doctors who helped shaped CUSS completed their medical training in Nigeria, and some were still based in Nigeria or other locations abroad when they were recruited to come work back in Cameroon. Dr. Victor Ngu, a native of Buea, was serving as head of the Department of Surgery in Ibadan, Nigeria before joining the CUSS faculty in 1971.<sup>678</sup> Dr. Gottlieb Monekosso, who completed his medical training in the UK and Nigeria, became the founding director of CUSS in 1969.<sup>679</sup> Dr. Thomas Nchinda joined the faculty in 1975.<sup>680</sup> Another founding faculty member, Dr. Daniel Lantum who had also completed his medical training in Ibadan, remembered the concentration of anglophone doctors at CUSS as a reflection of the different medical educational opportunities available to Cameroonians through the British and French systems:

President Ahidjo decided to bring some people from Nigeria to establish the first medical school here. Professor Monekossa was the first dean. Professor Victor Ngu was professor of surgery, and then myself and many others who were on the faculty, we were from Nigeria. So it means that Ahidjo realized the quality of education that Nigeria had at that time. When we came we found a few doctors, so called Cameroonian doctors, who were educated in Dakar in Senegal. The French had not established a very solid

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<sup>678</sup> Elie Claude Ndjitoyap Ndam, *De l'Aide de Santé..au Médecin. Réflexions sur la genèse, l'évolution et les perspectives de la formation médicale au Cameroun* (Yaoundé : Cameroon University Press, 2002), 89.

<sup>679</sup> Elie Claude Ndjitoyap Ndam, *De l'Aide de Santé..au Médecin. Réflexions sur la genèse, l'évolution et les perspectives de la formation médicale au Cameroun* (Yaoundé : Cameroon University Press, 2002), 90. Previous to his position at CUSS, Dr. Monekosso held a position in the faculty of medicine at the University of Lagos and then in Tanzania. After directing CUSS from 1969-1978, he went on to work for the WHO. Monekosso subsequently went on to become the Director of the WHO Regional Office for Africa (1985-1995) and the Minister of Health of Cameroon (1997-2000).

<sup>680</sup> Interview with Dr. Thomas Nchinda, May 22, 2014. Founex, Switzerland

system of education...and Ahidjo gave us the privilege to give that leadership.”<sup>681</sup>

Anglophone Cameroonian doctors thus carved out a new role of medical authority within the country through the creation of the first medical school in the country.

## Conclusion

The development of the DASP zones, on one hand, demonstrated continuation of the WHO’s reliance on “pilot zones” as a framework for health intervention, a form begun with malaria eradication in the 1950s and evidenced in Cameroon by the development of two pilot zones.<sup>682</sup> On the other hand, these developments represented an early turn towards investing in more comprehensive health services and away from the single-disease focused campaigns of the eradication era, a change heralding the broader the shift to an international focus on primary care in the 1970s. But in Cameroon, these shifts also entailed a reassessment of the French mobile health team model, and the embrace by Cameroonian health officials of the deep influence of the World Health Organization on the formulation of national policy. It was in part, paradoxically, the failure of this organization’s vision for malaria eradication that drove these changes. This change moreover did not coincide with independence, but became a long negotiation over the course of the 1960s, punctuated as well by the vital role of the mobile health teams in the Smallpox Eradication Program. The mobile health teams had thus played an absolutely central role in the “eradication era” in Cameroon, both in their colonial and postcolonial iterations. Moreover, the negotiation between Cameroonian, French and international health officials over the work of the mobile teams became the key framework

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<sup>681</sup> Interview with Dr. Daniel Lantum. November 1, 2013. Yaoundé, Cameroon. Although a full exploration of the function of language at CUSS is behind the scope of this study, Dr. Lantum recounted faculty teaching in both French and English at the university. One might give an exam written in the English and the students were permitted to respond in French.

<sup>682</sup> Amrith.

through which these officials debated questions of authority over the operation of rural health through the changes of decolonization and the first decade of independence.

## Conclusion

This project has shown how two central preoccupations of French colonial medical administration and of international health organizations, mobile health teams and disease eradication programs, became deeply intertwined in the postwar period and played a powerful force in shaping the Cameroonian health administration in the first decade of independence. The issues that Cameroonian, French and international health officials sought to fundamentally answer through negotiations over the mobile health teams—about the politics and provision of rural health in the face of low resources and personnel shortages—remained broached but never fully resolved. A brief overview of post-1970 developments will demonstrate that these questions took on new urgency, and became shaped by a multitude of new actors, in the face of economic crisis and epidemic outbreak.

In the 1970s, competing visions of investment in rural health centers and an ongoing reliance on mobile health teams continued to produce discord among the WHO, OCEAC and Cameroonian officials. Ongoing debates about basic health services in Cameroon in the 1970s took place in the context of the broader growth of an international movement promoting primary health care. In 1978, three thousand delegates from around the world met for the WHO-sponsored conference on primary health care at Alma-Ata. The ensuing Alma-Ata Declaration called for countries to work towards providing primary health care for all citizens. Marking a bold move away from postwar international health frameworks, the declaration called for community participation, and attention to the social and economic development as key determinants of health.<sup>683</sup>

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<sup>683</sup> Randall Packard, *A History of Global Health: Interventions into the Lives of Other People* (Baltimore: Johns Hopkins University Press, 2016), 227. Packard notes that while this was a departure from the postwar technical

Part of the WHO focus on primary health care included expanding immunization coverage as a key component of maternal and child health services.<sup>684</sup> This program sought to create more ongoing immunization services beyond the model of vaccination campaigns, in particular to respond to the failure to control measles in the course of the smallpox eradication program.<sup>685</sup> In 1975, Cameroon launched an expanded immunization program in Yaoundé through coordination with both OCEAC and the American CDC, and a country-wide program led by the WHO in 1977.<sup>686</sup> As the WHO called for this expanded immunization program to operate primarily through the personnel of fixed health centers, the ongoing French military leadership of OCEAC again pushed back against these recommendations, calling for continuing use of mobile teams.<sup>687</sup> Moreover, tensions developed between health personnel at local levels about shifting realms of responsibility between curative and preventive medicine.<sup>688</sup>

These fundamental problems of addressing rural health continued, but the 1980s marked a decisive turn in the capacity of the Cameroonian state to provide for any of these visions of rural health. The economic crisis of the late 1970s and the slashing of the health budget in the 1980s transformed the state health system. These national changes reflected a much broader international political and economic context of a turn towards neoliberal policies. In Africa, the World Bank and International Monetary Fund implemented structural adjustment program and

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assistance model of health, this also marked a return to approaches temporarily favored by international health organizations in the 1930s,

<sup>684</sup> Kristen Lucia Gray Jafflin, “The Power of Immunization: the WHO and Global Immunization Programs from 1974 to the Present” (PhD diss., University of California, Berkeley, 2013), 130.

<sup>685</sup> Jafflin, 135.

<sup>686</sup> Jafflin, 134.

<sup>687</sup> Jafflin, 142.

<sup>688</sup> Jafflin, 145.

austerity measures, which forced the reduction of state health budgets and the privatization of health services.<sup>689</sup> This period greatly undermined the building up of the system of rural health centers begun in the 1960s.<sup>690</sup> The state budget was also no longer able to support the kind of experimental work and training being done in the DASP zones.<sup>691</sup>

Following this time of economic crisis, austerity and privatization, the involvement of international organizations and charities in the health sector in Cameroon multiplied. The Cameroonian state faced severe limitations in centralizing or coordinating these diverse programs, or in setting health agendas autonomously.<sup>692</sup> The stakes of this coordination became greatly heightened in the face of the HIV/AIDS epidemic. With the outbreak of the AIDS epidemic and the failures of rural health provision in this context, the question of the relationship between hospital and mobile-based medical intervention gained new traction and urgency.<sup>693</sup>

The vestiges of the French mobile health teams and their postcolonial reorganization are still visible today in Cameroon. In terms of institutions, OCEAC still exists today in Yaoundé at the site of its original headquarters. The organization revised its objectives in 1983 and moved away from an emphasis on coordinating disease campaigns to a greater focus on being a

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<sup>689</sup> Meredith Turshen, *Privatizing Health Services in Africa* (New Brunswick: Rutgers University Press, 1999), 4-5.

<sup>690</sup> Nicolas Monteillet, « De la Méthode Jamot à la Médecine de Rue : Action Mobile d'Urgence et Action Sanitaire « de fond » au Cameroun. » *Politique africaine* 103 (2006): 137. Following the economic crisis, medications also stopped being free. Monteillet discusses how in this context, the “de-professionalization of the distribution of medications” flourished.

<sup>691</sup> Interview with Dr. Thomas C. Nchinda, May 22, 2014. Founex, Switzerland.

<sup>692</sup> Luc Serge Fongang, « L'évolution des politiques sanitaires au Cameroun (1920-2000). » in *Le Pluralisme Médical en Afrique : Colloque International de Yaoundé, 3-5 Février 2010 Hommage à Eric de Rosny*, directed by Ludovic Lado. (Paris : Karthala ; Yaoundé : Presses de l'UCEAC, 2011), 133-152. Josiane Tantchou, *Épidémie et politique en Afrique : Maladie du Sommeil et Tuberculose au Cameroun* (Paris : L'Harmattan, 2007), 34.

<sup>693</sup> Monteillet, 128.

central source of scientific and public health expertise to member states, as well as supporting the training of public health personnel. It is now an agency of CEMAC (Communauté Économique et Monétaire de l'Afrique Centrale), which expanded in the 1980s to include Equatorial Guinea. Much of the programming through OCEAC today focuses on the fight against malaria and against HIV/AIDS.<sup>694</sup>



OCEAC Headquarters. Author's photograph. July, 2011. Yaoundé, Cameroon.

The mobile health teams may, however, have also shaped the present day issues of public health in tragic ways both in Cameroon and beyond. Recent scientific research suggests that the mass campaigns conducted by the mobile health teams in Cameroon and French Equatorial Africa, particularly against yaws, syphilis and sleeping sickness, between 1910 and

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<sup>694</sup> *Historique de l'OCEAC*. [www.occac.org](http://www.occac.org), accessed February 4, 2017.



1960 may have been one of the factors that amplified the early spread of HIV among human populations.<sup>695</sup> In this sense, these campaigns may have indeed shaped the current landscape of global health and the disease burden faced by people of Equatorial Africa in profound ways. This burden is seen not only through the disease of HIV/AIDS itself, but also the way in which the mobile team model, fortified by the pursuit of disease eradication, historically perpetuated “campaign style” public health, a model cast as being at odds with the development of a more stable health infrastructure, one with potentially greater capacity to respond to the emergence of new diseases and public health crises.

At the local level within Cameroon, some have moreover argued that the colonial mobile health teams created “a popular imaginary of medicine privileging injections and pills,” and in turn contributed to the contemporary proliferation of unregulated “street medicine.”<sup>696</sup>

Although the memories of the mobile health teams certainly form part of the landscape of memories of older Cameroonians, this claim gives perhaps undue power to these older

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<sup>695</sup> There is general scientific consensus that the crossover of a disease (Simian Immunodeficiency Virus or SIV) from non-human primates to humans occurred in the first half of the twentieth century in West and Central Africa. That virus adapted in the human population to become what we call HIV. The particular strain of HIV-1M is believed to specifically have originated in southeastern Cameroon. The way that the disease spread among human populations has been a topic of great interest to scientists, but other scholars of Africa (historians, anthropologists) have more recently begun to study the spread as well. Many factors may have contributed to the spread of the disease including injection and vaccination campaigns with unsterilized needles, blood transfusion, and social factors spurred by urbanization particularly in the areas of Brazzaville and Léopoldville (present day Kinshasa). For a succinct work on some of the scientific research that has led to these conclusions: Jacques Pepin and Annie-Claude Labbé “Noble goals, unforeseen consequences: control of tropical diseases in colonial Africa and the iatrogenic transmission of blood-borne viruses” *Tropical Medicine and International Health* 113. 6 (2008): 744-753. For a more extensive work: Jacques Pepin, *The Origin of AIDS* (New York: Cambridge University Press, 2011). For reflections on how historians of Africa can contribute to these questions: Tamara Giles-Vernick et al. “Social History, Biology, and the Emergence of HIV in Colonial Africa,” *Journal of African History* 54 (2013): 11-30. These authors, while recognizing the role that out of the ordinary events, such as disease campaigns, may have played, also call for attention to continuities and closer examination of longer term practices of human mobility and medical practice that may have shaped the spread of HIV.

<sup>696</sup> Monteillet, 127. Monteillet argues that the mobile health team method established a dangerous precedent of urgent medical care disconnected from long-term contact with biomedical care or health education. He connects this precedent to the contemporary surge of people self-medicating with unprescribed pills and injections, which at times have led to dangerous drug resistances.

experiences in forming contemporary subjectivities, giving them equal weight to the profound structural factors rooted in the weakening of state medical budgets, which limit Cameroonians' experience of and access to biomedicine in the settings of hospitals, clinics and pharmacies. In contemporary Cameroon, just as in many other African states, "your pocket is what cures you," meaning that the ability to pay or not pay for medical consultation or medicines becomes a stark dividing line in access to biomedical care.<sup>697</sup> Where this claim offers insight, however, is in placing the mobile health team service in a longer history of biomedical encounters outside of the hospital setting, and outside of the framework of a doctor-patient interaction. In this longer arc, the experience of biomedicine becomes marked by its own particular framework of medicine disconnected from individualized care and its implementation justified by conditions of limited resources. Here, we might see the mobile health teams as a formative stage in a politics of biomedical care for the majority of people as framed by urgency and scarcity.

On a more global scale, the goal of the global eradication of single diseases, an idea that for a time fell into disrepute, has gained a powerful new advocates. After many in the international health community discredited the idea of malaria eradication due to the major failings of the postwar program, the Bill & Melinda Gates Foundation announced in 2007 that its goal for malaria work was eradication.<sup>698</sup> The Gates Foundation has also been a major player in an ongoing polio eradication program, first approved by the WHO in the late 1980s.<sup>699</sup> In Cameroon, the issue of polio spread continues to be framed through familiar geographic pathways. Cameroon remains a "key at risk" country for the global polio eradication campaign

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<sup>697</sup> Ellen E. Foley. *Your Pocket is What Cures You: The Politics of Health in Senegal* (New Brunswick, N.J: Rutgers University Press, 2010).

<sup>698</sup> Stepan, 255.

<sup>699</sup> Stepan, 225.

due to Nigeria being one of only three countries in the world that still suffers from endemic polio. In 2016, Cameroon declared a regional public health emergency following an outbreak of the disease in northeastern Nigeria.<sup>700</sup> The sources of funding and influence for these new programs, shaped by new private philanthropies such as the Gates Foundation, at the same time represent a vastly transformed landscape of global health from the field of international health in the 1960s.

Tensions of global ambitions for disease eradication, the challenges of rural health intervention, and the sometimes opposing forces of medical and population movement, thus continue to shape many of the questions of public health in Cameroon today, albeit in new ways. As this project has shown, it was in the postwar period and the first decade of independence that these fundamental problems became reformulated, through the mobile health teams, from questions of colonial governance to ones of the independent state, and this process took place in an inherently international context. Yet, if this period of state-centered development ultimately culminated in a turn away from the framework of disease eradication, and a more serious investment in permanent public health infrastructure, the ensuing decades of economic crisis and the new imperatives of contemporary global health have recycled old questions for new times.

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<sup>700</sup> [www.polioeradication.org/where-we-work/cameroon](http://www.polioeradication.org/where-we-work/cameroon). Accessed February 4, 2017. This site represents the Global Polio Eradication Initiative “a public-private partnership led by national governments with five partners—the World Health Organization (WHO), Rotary International, the US Centers for Disease Control and Prevention (CDC), the United Nations Children’s Fund (UNICEF) and the Bill & Melinda Gates Foundation. On the Polio Eradication campaign in Nigeria: Elisha P. Renne, *The Politics of Polio in Northern Nigeria* (Bloomington: Indiana University Press, 2010).

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## Appendices

**Table 3: Medical and para-medical personnel in Cameroon 1964/1965 <sup>701</sup>**

Qualification	East Cameroon			West Cameroon			Total Federation		
	Public	Private	Total	Public	Private	Total	Public	Private	Total
Docteurs en médecine, Médecins Africains * /Doctors, “African Doctors”	112	52	164	15	17	32	127	69	196
Infirmiers diplômés d’Etat/ State registered Nurses	179	114	293	107	54	161	286	168	454
Sages-Femmes diplômées d’Etat/ State registered Mid-Wives	33	7	40	28	11	39	61	18	79
Infirmiers brevetés/Licensed Nurses	468	6	474	71	--	71	539	6	545
Infirmiers à diplôme non reconnu/ Non-certified nurses	1886	405	2291	67	24	91	1953	429	2382
Non diplomes-Auxiliaries/ Auxiliaries	495	703	1198	--	240	240	495	943	1438
Manœuvres-Domestic Personnel/Unskilled workers	1565	174	1739	227	256	483	1792	430	2222
Total	4738	1461	6199	515	602	1117	5253	2063	7316

\*These numbers include French personnel.

<sup>701</sup> BNF. Cameroun, Ministère des affaires économiques, *Plan quinquennal de développement économique et social : 2<sup>e</sup>, juillet 1966-juin 1971/Five-year plan of economic and social development, 2<sup>nd</sup>, July 1966-June 1971*, 422.



**Table 4: Medical Establishments in Cameroon 1964/1965<sup>702</sup>**

		Hospitals	Leprosy Hospitals	Dispensaries	<b>Total</b>
<b>East Cameroon medical establishments</b>	Public Health	31	29	138	<b>198</b>
	Local councils (communes)	--	--	310	<b>310</b>
	Private	22	7	192	<b>221</b>
	Total	53	36	640	<b>729</b>
<b>West Cameroon medical establishments</b>	Public Health	7	--	--	<b>7</b>
	Native Local Councils	--	--	40	<b>40</b>
	Private	11	2	51	<b>64</b>
	Total	18	2	91	<b>111</b>
<b>Federation medical establishments</b>	Public Health	38	29	138	<b>205</b>
	Communes, Native Auth.	--	--	350	<b>350</b>
	Private	33	9	243	<b>285</b>
	Total	71	38	731	<b>840</b>

<sup>702</sup> BNF. Cameroun. Ministère des affaires économiques, *Plan quinquennal de développement économique et social : 2<sup>e</sup>, juillet 1966-juin 1971/Five-year plan of economic and social development, 2<sup>nd</sup>, July 1966-June 1971*, 424.